SARS PUBLIC HEARINGS

****

BEFORE: THE HONOURABLE MR. JUSTICE CAMPBELL,
COMMISSIONER

Held at: St. Lawrence Market
Toronto, Ontario

****

September 30th, 2003

APPEARANCES

Doug Hunt Jennifer Crawford	)Commission Counsel)
Ron Bain	Senior Investigator

TABLE OF CONTENTS

	Page
Dr. Richard Schabas	4
Dr. James Young	29
St. Michael's Hospital	51
Customs Excise Union Douanes Accise	69
Canadian Union of Public Employees	76
Service Employees International Union	96
Ontario Public Service Employees Union	110
Ontario Ministry of Health & Long-Term Care	133
North York General Hospital	143
Scarborough Hospital	159
Ontario Hospital Association	176
Ontario Association of Radiologists	192
Certificate of Transcript	209

--- Upon resuming at 10.00 a.m.

MR. JUSTICE CAMPBELL: The first presenter this morning is Dr. Richard Schabas who is the Chief of Staff at York Central Hospital, formerly the Chief Medical Officer of Health for the Province of Ontario.

DR. RICHARD SCHABAS: Thank you, Commissioner Campbell. It's my great pleasure to be here this morning and I very much appreciate the opportunity to make this presentation to you.

I am, as you said, currently the Chief of Staff at York Central Hospital. I want to make it clear, though, that the views that I'm going to express this morning are my own views and not necessarily those of the hospital or its Board of Trustees.

Having said that, I want to say how proud I am to be associated with York Central Hospital. It's a hospital that suffered a great deal of adversity in the early days of the SARS outbreak and I think showed tremendous resilience and ultimately, I think, considerable leadership in rebounding from that. You're going to hear more about that tomorrow evening.

I'd also like to say that I think that the people who are, I would say, are the real heroes in this SARS experience in Toronto, and heroes is not a word I think we

should use lightly, are the healthcare workers, hospital workers at hospitals like York Central Hospital who went to work every day in spite of the very real and understandable fear of SARS and fear of the unknown and it was their diligence and dedication that kept our healthcare system running in those difficult days.

I've seen co-workers become ill with SARS and I know what a devastating illness it can be. I also want to express my sympathies for those people who did become ill and, of course, particularly for the families of those who died during the outbreak.

The spirit of my presentation is about learning from mistakes. I think we made some mistakes, I think we can learn from those mistakes. I think the first step in learning from mistakes is to identify those mistakes, but it's not about blame, it's not about finding fault with individuals.

I also want to say that although I think some people may be upset by my comments, I am in no way implying any criticism of front-line public health workers. I think they did diligently and well the jobs they were asked to do. My concern is that all too often, they were not asked to do the right jobs.

I'd like to begin by just reflecting a little bit on my own personal odyssey with regard to SARS. I first

heard about SARS on March the 15th, Saturday March the 15th, through an article in the Globe and Mail when SARS was being touted as an impending pandemic. I must say that initially, from the very beginning, I had some scepticism about that advance billing.

Even from the very beginning, there were some important pieces of information, specifically the fact that SARS, even though it had apparently been active in China for three (3)or four (4) months had only affected case counts, at that time, in the thousands, not the tens of thousands or hundreds of thousands, and also the fact that it was primarily affecting health care workers, not a characteristic of a pandemic organism.

However, I watched with some -- obviously with great interest, and some alarm, the events as they transpired over the next twelve (12) days, but on March the 27th, my wife and I left on our vacation to Europe and not thinking we were directly involved with SARS, and to my horror, two days later I was informed by cell phone by my daughter that my hospital was closed and I was supposed to be in quarantine.

So I followed that direction and quarantined myself in an apartment in Paris, but I spent those eight (8) days staying in touch as best I could with the SARS situation, through French television and through regular telephone calls and tele-conferences with my colleagues at

York Central Hospital and in public health in Canada.

And, I must say, over that period of time I developed some concerns that in fact we were not dealing appropriately with SARS; that it was not as it necessarily appeared to be.

When I was allowed to return to Canada, I returned to work on April 7th, those concerns were very quickly validated by what I could see around me at York Central and what I could gather from the rest of the Toronto situation.

And I spent a considerable amount of time that week working the telephones, phoning people I knew who were involved in the provincial control efforts - Dr. Young, Dr. Schwartz, Dr. Zootman and others to tell them about my concerns, to express my opinions about what I thought we could be doing better, and in particular, to offer to come down and assist them with their SARS control efforts.

I had considerable experience as a senior public health official in Ontario and to my knowledge, was the only person with such experience who also had experience in hospital administration and, in fact, that was the gap -- that was the gap that yawned so wide, I think, in our SARS control efforts.

My telephone calls were received politely, but no action was taken. So, by the beginning of the next week,

the week of April 14th, I felt that there was a need for me to speak out in some manner about what was happening.

If you can cast your mind back, April 14th was the week where we were told that the virus was mutating, it was now attacking young people, it was very infectious. We went through the whole episode with the GO-train incident. There was a very high degree of anxiety, I think verging on panic in Toronto.

Now I knew that I was going to have to speak out on this, but I also knew that what I had to say was going to be very different than what people were being told by the commonly quoted experts and I wanted to be sure that what I said was said carefully and precisely.

So I approached Dr. John Hoey (phonetic) at the Canadian Medical Association Journal and with his encouragement I spent the week writing an editorial which I then submitted at the end of that week and which was published, I think, with commendable speed on the Internet on April 23rd.

In fact, that same day I was approached by the Toronto Globe and Mail and asked to write an opinion piece which was published the next day. And I say this because I want to make it clear and I will make it clear that I think hindsight is a very -- a very commendable and useful tool for this Commission.

9

But I also want to say that the criticisms and comments I'm going to make today are not simply made in hindsight. I think they've been validated in hindsight but they -- but basically the fundamentals of what I'm going to say today I've said in those articles in April.

I'm going to structure my presentation around three (3) issues. First of all, to try to analyse what happened in the SARS outbreak, what was SARS really all about. Second of all to address the question of what could have been done better? What was it we did that worked? What is it we did that didn't work?

And, finally, to address the issue of, what should have been done better? What were the flaws in our system? What were the things that we should have known better about and done better with?

I'm going to begin though with a little bit of an expression of caution. Caution about two (2) things. I think that if SARS has taught us anything at all it's that we have to maintain our sense of scepticism, our sense of being critical.

You're going to hear a great deal over the course of these presentations about something called "the new normal". About the steps we have to take because -- as a consequence of SARS. And I'm going to suggest that you take those recommendations with a certain amount of scepticism.

10

Not because they're not well-intentioned and not because they aren't necessarily learned from the experience of SARS but because we also have to have the perspective that the SARS experience in Toronto was an extraordinary and unusual set of circumstances; that if we take a step backward from a global perspective, diseases like SARS, as best we can tell, new viruses that emerge and cause significant illness are not common events. They're events that occur on a timescale of decades, not a timescale of years.

And from an individual city's perspective, Toronto was extraordinarily unfortunate to be hit by SARS but there were hundreds of other cities fundamentally similar to Toronto that were not so affected. So we need to approach this, I think, not just from the perspective of Toronto but perhaps from the perspective of Buffalo or Buenos Aires.

With regard to the key question about the new normal, will SARS come back? Frankly, it's my opinion that this is unlikely but certainly not impossible. But, if SARS does come back, I think the overwhelming probability is that SARS will come back in China, not in Canada, either because of a repeat species jump or because there's some undetected chain of transmission there.

And if that happens, I think we have every expectation that we will get significant advance warning,

twenty-four (24) hours is probably all we really need, but significant advance warning and the probability that it will leap from China to Toronto again is really no greater than the probability it will leap to many other cities. In other words, very small.

And, finally, as I'll point out, I think we have learned, perhaps in some ways the hard way, but we have learned how to control SARS outbreaks when they -- when they occur and to minimize their impact.

I'm also going to express some concern about what I call swine-flu-think. I think this played an important element in mistakes being made around SARS. And what I mean by swine-flu-think is to cast our minds back to the middle years of the 20th Century when there were two (2) Influenza pandemics. The Asian Flu in 1957, and the Hong Kong Flu in 1968.

And it became the conventional wisdom among public health experts, based, I must say on reflection, on rather scanty evidence that Influenza epidemics occurred on a ten (10) year cycle. And so by the mid-1970s there was a high degree of expectation that we were expecting another Influenza pandemic.

And so, when three (3) soldiers -- three (3) American soldiers became sick at a military base in New Jersey with a new swine flu variant virus, the conclusion was

rapidly jumped to that this was the next pandemic and a program was undertaken to immunize ultimately 40 million people immunized for the epidemic that never happened.

I think to some extent we saw the same phenomenon with SARS. Over the last couple of decades there's been a great deal of hype creating the expectation that we're about to face another great new pandemic disease and I think again, on reflection, perhaps not always on the firm of scientific evidence.

So when SARS did emerge, it emerged in a public health community that was fertile ground for the expectation of a new pandemic. The sense of expectation was high and I think this expectation clouded our judgement. It was, I think, a classic example of believing is seeing.

Okay, I want to turn now to the details of the SARS outbreak in Toronto. What I've displayed on the screen here is the epidemic curve of the SARS outbreak.

Now, an epidemic curve, however complicated it may look, is actually quite a simple diagram. It simply plots cases by the day in which the symptoms develop, then there's a bar.

So if there's one (1) case, the bar is one (1) high. If there are five (5) cases on that day who developed their symptoms on that day, it's five (5) high. And an epidemic curve is the way that we're taught to represent

infectious disease outbreaks, that's a very simple basic infectious disease epidemiology.

Now, a couple of comments about this particular epidemic curve. First of all, I borrowed it from the Health Canada SARS website and I'd like to acknowledge that. Second of all, it's all of Canada. So there actually are, I believe, four (4) British Columbia cases here.

Now, I can't -- don't have the technical expertise to remove them but defacto, this is the Toronto outbreak. The third point is that it only represents probable cases and I believe that's the right way to represent the SARS outbreak and to understand it best and there are three (3) reasons for that.

First of all, it's the probable SARS cases which in effect means the people who had SARS pneumonia. That -- they're -- these are the people who suffered some significant burden of illness. It gives us a better idea of the real burden of illness from the outbreak.

Secondly and probably most important, by only including the probable cases, namely those people who, as the name suggests, probably had SARS, we actually get a clearer picture. We remove background noise which we would introduce by including, for example, the suspect SARS cases. And it really -- in understanding an epidemic curve, it's really the pattern that's most important, not the height of the bars.

Thirdly, this is the international standard. This is the way that Health Canada represents SARS data; it's the way the WHO represents SARS data; it's the way the public health officials in Beijing, Hong Kong, and Singapore represent SARS data, by probable cases. In fact, the only jurisdiction that seems to insist on lumping together the probable and suspect cases is Ontario and I guess, Toronto.

Now, in looking at this epidemic curve, I want to make two (2) key observations. The first relates to the people who got SARS. Now, Health Canada has very nicely colour coded the four (4) groups of people by their route of transmission.

The red are the travel cases, people who came from China with SARS pneumonia. The yellow are people who acquired SARS in a healthcare setting, almost entirely -- but not exclusive, but almost entirely in a hospital setting.

The blue crosshatched are people who are household contacts, predominantly of people who initially got it from a healthcare setting but in a few cases, from a travel case. And the black, and there are only a handful of those at the first part of April, black are those who are the other verb, our so-called community cases.

Now, the key message when you look at this diagram, of course, is the overwhelming predominance of yellow. Fully 80 percent of the cases in the Toronto

outbreak were healthcare transmission, as I said almost all hospital transmission.

Of the others -- of the other 20 percent, virtually all of those were household transmission and there is virtually no commu -- there are virtually no community cases and more importantly, there's no sustained transmission in the community.

What does this tell us about SARS? I think the only plausible explanation for this pattern and spread is that SARS, in spite of what you might have heard, SARS is not actually a highly infectious disease and that, in fact, fits the key facts that we know about SARS.

We know -- in fact, we've known for considerable time that the route of transmission is by respiratory droplets and we know that infections like Tuberculosis that are spread by respiratory droplets are not considered highly infectious. They require prolonged close contact with an infected person to spread the disease.

Second of all, we know about SARS that, in fact, the window of infectivity is quite narrow and that typically it's people who are very ill with SARS who are significantly infectious.

So, if you think about it, it's exactly those sorts of circumstances, that combination of circumstances that promotes spread in hospitals. That's where sick people

go and that's where they're kept in close proximity with their caregivers and, unfortunately in some of our overcrowded emergency rooms and ICU's, with other patients. And that's how it was spread.

To some extent, the same circumstances are duplicated in a household setting which is why we've got household cases. But there's a third factor that predisposes to hospital spread and that's that in hospitals we tend to use interventions, particularly forms of non-invasive ventilation, that actually have the unfortunate consequence of spreading respiratory droplets and increasing the infectivity of SARS.

And I think if we look closely, particularly in SARS I at some of our super-spreaders, in fact, we'll discover that they weren't so much super-spreaders as super-spread.

But, again, the key message it's not the absence of community cases, of course, as with any disease of this kind, you can get some cases in the community but the key point is that there's no evidence of sustained transmission in the community.

And even in those outbreaks elsewhere in the world, specifically in Hong Kong and in Beijing where there were significant community clusters, in fact, it didn't go anywhere from there.

Second point I'd like to make relates to the shape of the curve. Infectious disease outbreaks classically follow a bell shaped distribution. They start slowly, they increase rapidly to a peak and then they decrease almost as rapidly as they started. That's typical, text book stuff for infectious disease outbreaks and I think the pattern here describes that.

But to make it perhaps even a little clearer, because this is done on a day-by-day basis and introduces perhaps a little bit of statistical noise, what I've done here is just chart out the course, the same epidemic curve but on a weekly basis, which in SARS I think is comparable to the median incubation period. It's probably the best way of doing it and I think the pattern of the bell-shaped distribution is really very clear here.

The importance of this is that experience teaches us with outbreaks of this kind that if they're not increasing rapidly, cases are not increasing rapidly, that there's every expectation that, in fact, they're doing the opposite, that we are over the peak and things are getting better.

Now, I'd like to turn back to the epidemic curve and I'd like to make a couple of points but I'm going to go up to the Board -- up to the screen if I might.

Looking at this diagram and I'll look first at

SARS I, the first outbreak in -- primarily in March and a little bit in April. The key event here, as displayed in this diagram, was the date when the rate of new cases peaked.

And that was on or about March 25th. Similarly, in SARS II the rate of new cases peaked on about May 29th. Now, what you have to understand though is that this is charting the day on which people became ill. In disease control terms the important event is not the day people become sick, it's the day they become infected.

And with SARS that occurred, on average, about a week earlier. So that tells us that in SARS I the actual peak of infection, the crisis point of the outbreak occurred sometime prior to March 20th.

And that the measures that were undertaken in Scarborough Grace Hospital between March 14th and March 20th were those measures that ultimately were crucial in controlling this outbreak and they were predominantly the simple measures of putting -- isolating sick people in private rooms and nursing them with masks and gowns.

Similarly, with SARS II, the peak of cases was on May 29th which tells us that the peak of transmission was on or about May 22nd, the very day that the outbreak was discovered.

So what this says is, in fact, that the key to controlling a SARS outbreak is to identify that we have one.

And that's a pattern that's repeated elsewhere in the world *as I'll explain in a few minutes.*

And as we can see with SARS II, remembering the sorts of measures that were undertaken to control SARS II were far less draconian than those with SARS I but, in fact, it was astonishingly effective at controlling that outbreak.

Now the other thing we have to remember, and again to be fair to public health authorities, as I say, this is the picture of when people got sick, we have to, in our mind's eye, imagine the picture of infectivity which occurred about a week earlier. We also have to remember that this data sometimes took a little time to accumulate; they didn't acquire it in real time.

So, there was a lag of at least a few days before we could reasonably be expected to see the patterns which are now so clear to us.

However, relating the key events of the outbreak to this epidemic curve, I want to begin with March the 14th. March the 14th was the day, which according to media reports, public health authorities and the Ministry of Health became aware that they had an outbreak of SARS-like illness at Scarborough Grace Hospital.

At that point in time, relatively few people were infected with SARS and with all the wisdom of hindsight, if we'd taken more decisive action at that point in time, the

outbreak would have been dramatically curtailed.

I can say that from the perspective particularly of York Central Hospital because even the simple expedient of putting a freeze on transfers from Scarborough Grace Hospital to other hospitals on March 14th, would have saved York Central Hospital the tragedy that ensued there when a patient was transferred without any warning of the possibility of SARS on March 16th.

In fact, Scarborough Grace Hospital was not closed until May 23rd, nine (9) days after the outbreak apparently was identified and actually three (3) or four (4) days after the outbreak was, in effect, brought under control.

It was March 26th that the provincial emergency was announced and March 28th that the drastic closure of the hospital system throughout the GTA was announced. All events which in hindsight we knew happened really after the crisis point but, I think in fairness to the officials making them, was something they could not have known at that time.

However, we then enter a four (4) week period between March 28th and April 23rd where, in fact, authorities persisted with the draconian measures, the draconian control measures that were introduced in March, in spite of the fact that there was rapidly emerging information that in fact this

21

outbreak was not spreading, this outbreak was controlled, and this outbreak was not a serious threat to the community.

And that information came not only from our situation in Toronto but from what we were learning about what was happening elsewhere in Hanoi and in Singapore and even in Hong Kong, information that was available on the World Health Organization website with epidemic curves similar to this showing those outbreaks either over, as the Hanoi outbreak was, or in rapid decline.

In spite of that, this was the period of time in which we had daily media briefings that by presenting, not new cases as I've done here, but cumulative cases. It's a little bit like the meteorologist on television reporting the cumulative annual rainfall, rather than the daily rainfall.

Not actually useful information, I think this demonstrates, but creating the impression of a large and growing outbreak by lumping together suspect cases and probable cases and by emphasizing the deaths.

Now, all of that resulted in or reached a peak, on the Easter weekend, the weekend of April 19th when the Ontario government published quite extraordinary full page advertisements in the Toronto newspapers which basically said that anybody with a fever or a bad headache or bad muscle aches or fatigue might have SARS and should isolate themselves.

22

And again, maybe I will indulge myself and just go to the screen and show you where that point is on the epidemic curve.

I should add that on April 21st, York Central Hospital was able to re-open after its closure as a category 3 hospital and it re-opened with a pneumonia control and SARS surveillance protocol in place.

The next step was April 23rd when the World Health Organization issued its unfortunate and ill-advised travel advisory. But what we witnessed then was a remarkable change in attitude from provincial officials who, just three (3) or four (4) days earlier, had been warning millions of people that they might be at risk for SARS, to suddenly say to the world, no, there's not risk of SARS here.

And unfortunately what we did was we flipped from a state of SARS panic to a state of SARS denial, because as SARS I was petering out we made the crucial error of not introducing any program of active surveillance for SARS.

In fact, it was worse than that because if we look at the early days of May, on May -- I believe, May 8th, the City health department announced that the outbreak was over. On May 12th the Chief Medical Officer of Health for Ontario was quoted in the Toronto Star as saying "it was preposterous", his word "preposterous" that someone could have acquired SARS in Toronto in late April.

I'm going to pause on those two (2) events because I think there are some important lessons. First of all, we have to realize that with there being no program of active SARS surveillance in place in Toronto there was no basis for saying that the outbreak was over. It was, in fact, an exercise in wishful thinking.

But even more so, the suggestion that it was ridiculous to consider that there might be cases, pointing ridicule at the suggestion there might be cases was sending out entirely the wrong message.

The key to controlling a disease like SARS is finding it. We should encourage -- we should have been encouraging people to find cases of pneumonia that might be SARS so that we could investigate them and eliminate the possibility.

By, in fact, discouraging SARS it took, I'm sure, ultimately a very brave person to come forward and say that, in fact, we still had a SARS problem.

As we move through May and you can see the up sweep of SARS II. In fact, by May 22nd, the day that SARS II was discovered, there were already almost fifty (50) people who had developed SARS illness.

But, again, as I reflect on the control measures introduced on those days, basically the simple measures of nursing in private rooms, basic personal

protective and putting a freeze on transfers between hospitals turned off SARS II almost like flipping a switch.

The last date I'll point out is June 16th, that was the day on which the provincial government finally adopted a SARS surveillance protocol. One that was basically founded on the York Central Hospital protocol which had been introduced almost two (2) months earlier.

What I have here, just by comparison, is the outbreak in Beijing and I just want to make the point that, although the Chinese authorities basically ignored their outbreak for more than a month and allowed it to grow -- and the height of the bars here is much higher. The Beijing outbreak was an order of magnitude larger than the Toronto outbreak.

Basically allowed their outbreak to continue unchecked for the better part of a month, when they finally identified the problem and put control measures in place, it was brought under control within a matter of a couple of days, but they're a typical pattern.

What are my concerns? My concerns are, fundamentally, that we failed to take the measure of SARS. We failed to understand what it was about and we did that because we didn't put sufficient emphasis on data collection, data analysis and learning about the infection.

Second of all, I'm concerned that we spent a

25

lot of time on unnecessary, unhelpful, and harmful intervention. Some of the deepest wounds with SARS were the self-inflicted wounds and I want to highlight three (3) of those.

First of all, the massive hospital shutdown throughout the GTA, throughout most of the month of April, which we can now see from the -- from the evidence of SARS II was not a necessary measure and something that was heavily criticized at the time.

Second of all, the widespread use of mass quarantine. Time doesn't allow me to go into this in detail in this presentation but I want to make the point that, in fact, quarantine was a strategy that was fundamentally abandoned by public health a hundred (100) years ago, and I think careful analysis will show that it played little or no role, but it came as a -- at a cost.

It sapped the resources of public health. Public health people were too busy running around quarantining to do the much more important jobs of identifying the people truly at risk and capturing and analyzing the necessary information and also I think it fed the general sense of public panic.

The third thing I want to highlight is the use of airport screening and airport scanners. You don't have to do too much mathematics to understand that the probability

26

that this would contribute anything at all to the benefits of SARS control are very, very small.

And I think the experience around the world has shown that. I know, for example, in Beijing at the height of their outbreak they screened two hundred and seventy-five thousand (275,000) people leaving the airport and found no cases of SARS.

Thirdly, I want to talk about public communications. I've already talked about the misleading way, the unscientific way in which evidence was presented creating the impression of a large and growing outbreak when the opposite was the case.

And, finally, the fact that there really was no surveillance strategy. A cornerstone of public health, the most important thing, in a sense, that that public health does with regard to infectious diseases is surveillance and, as I've said, the key to controlling SARS is identifying SARS.

So, what happened? Well, SARS was fundamentally an outbreak in two (2) connected hospital-centered outbreaks by a new virus that's virulent in the sense that it makes people very ill, but not very infectious.

What could have been done better? Well, it was basically controlled by the sorts of basic infectious

27

control procedures introduced in hospitals between March the 15th and March the 20th and on May the 22nd as I've described. Clearly there could have been faster action and clearly there could have been a greater emphasis on evidence-based practice.

What should have been done better? We should have had evidence-based communication, we should have had surveillance and I think at critical points we could have had faster action.

I'm only going to make one recommendation. There are many operational issues that I'd like to have the opportunity to discuss but clearly time does not allow.

I think the key weakness that the SARS outbreak pointed out in our public health system is a lack of strategic capacity, a lack of really expert leadership in a crisis situation at that time.

We have -- that capacity has been largely eroded at a provincial level over the past few years and there really was no acceptable alternative within public health.

Now, I've argued through my whole professional career about more resources for public health in general and of course I support that but, I think that public health in this circumstance was stretched to the limit as much because it spent its time doing the wrong things as because it didn't

28

have enough resources as a whole.

What do I mean by that? I mean better resources either at a provincial or a national role. There's been a lot of talk about creating a national level CDC equivalent. I think we need something like that.

If it doesn't work at a national level, I think we need to strengthen our provincial strategic capacity. I think we need to make sure that there is expertise in public health in dealing with hospital infection control issues.

SARS is an excellent example but by no means the only one, where these issues overlap and in fact these, up until know, basically have been two (2) solitudes.

Thirdly, I think it has to be arms-length from the political process. I've avoided discussing the impact of politics on this outbreak but I think that to ensure that there's public credibility, that the public understand that the public health officials are acting only in the interests of public health and are not influenced by political considerations, that this has -- or that we have to put greater political distance between our senior public health officials and the politicians.

And, finally, I think we near clearer lines of authority within our public health system. At the moment, local public health authorities are not directly answerable

29

or reportable to the provincial authority and I think, particularly in a crisis like SARS, that's something that's important.

So, thank you for giving me this time. I hope that we can learn from the experience and emerge stronger as a result. Thank you.

MR. JUSTICE CAMPBELL: Thank you for your presentation.

The next presenter is Dr. James Young, the Commissioner of Public Safety for the Province of Ontario.

DR. JAMES YOUNG: Morning, Justice Campbell. I'd like to begin my remarks by expressing my condolences to, on behalf of the entire SARS team, to all of the families who lost loved ones and to everyone who suffered through SARS during this outbreak.

Each and every time we had either a new case, and in particular a death, that certainly strengthened my resolve to try to control this outbreak.

I believe the work of the Commission is extremely important. It is most important, and I hope my remarks reflect it today, that we understand the outbreak as well as we can, because I believe that some of the measures in containing outbreaks in the future and controlling situations will be from lessons learned from this outbreak.

And I believe that we will get future

30

directions for the entire healthcare system. For example, Justice Campbell, if I had proposed two (2) years ago that hospitals in this province spend four (4) or five (5) times the amount of money on infection control, and take many of the measures that we now feel are necessary because of SARS, I would have received tremendous argument from people saying, it's not necessary; we need the resources in other places.

So clearly, priorities change and SARS is one of those watershed times when we, in fact, learn that we have to do things differently than we have done them in the past.

Our goals in managing the SARS outbreak, first and foremost, were to protect public safety including the public safety and health of our healthcare workers. We obviously were concerned about protecting them from infection and, most certainly, from death.

Our second goal was to produce minimal disruption to the rest of the healthcare system while putting in place the necessary protections for the healthcare system. The third was to minimize the geographical spread of SARS. The fourth was the public reassurance and dissemination of information both to healthcare professionals and to the general public.

And the fourth -- and the final was to minimize both the social and economic disruption as a result of something like SARS.

31

We were given certain tools in which to manage and our û our efforts were guided by these tools. The first was to try to use science and base our judgments on the best science that was available, at that time, in which to make our decisions.

The second was to make ethical decisions. The third, wherever possible, was to honour confidentiality, particularly in regards to healthcare information while at the same time appearing to be transparent and provide as much information as we possibly could.

Our team was made up of a very large, multi-disciplinary team which did pull in the same direction and were led by front line healthcare workers. Those healthcare workers include the paramedics, the public health units, the people in the emergency departments, the people throughout the hospital system, people in long-term institutions and doctors' offices.

The story in Toronto, as you're aware, starts with a case that came from the Metropole Hotel. It appears to be quite clear, in retrospect, that the outbreak of SARS started in Guangdong Province in the late fall. This was not reported, and a doctor from Guangdong Province went to the Metropole Hotel for a wedding.

While at the Metropole Hotel, he stayed on the ninth floor of the Metropole Hotel as did a Canadian couple.

32

The first known infected Canadian from SARS then was one of the people at the Metropole Hotel and it is the couple at the top that I'm talking about and the lady, in particular, is the circle with the line through.

She became our index case in Toronto. She got back to Toronto and was ill and subsequently died and the connection between her illness and her other illnesses were not recognized and it was not recognized at the time that she had died from an infectious disease that she had caught in Hong Kong.

Her son became ill and he is on the second line with a line through, and he is the patient who went to the Scarborough Grace Hospital on March the -- late in the evening of March the 7th and March the 8th. After about sixteen (16) hours he was isolated. He subsequently deteriorated in health and died on March the 13th, and those dates are important.

In fact, the other people in the shaded boxes on this chart were relatives who got ill with SARS, all on March the 18th, all of whom were isolated at the time that they -- that they became ill.

The first definitive description of SARS, although it was not called SARS, came from the World Health Organization on March the 12th, so three (3) to four (4) days after the first Toronto patient was admitted to hospital.

33

It was described as an atypical pneumonia; it was described as affecting healthcare workers. It was from an unidentified cause ,at that time, and it was believed to be spreading through South East Asia.

The name SARS did not appear until the second directive from the World Health Organization on March the 15th, and you'll recall that the index patient in Toronto died on the 13th of March.

In fact, despite the isolation that was put on at the Scarborough Grace Hospital, unfortunately, other patients did become infected with SARS, initially, and this, what looks like a confusing graph, illustrates that the first patient gave it to her son, her son gave it to a series of relatives and unfortunately, while he was unprotected in the Scarborough Grace Hospital, several other -- two (2) other patients became infected and they, in turn, infected a large number of û- of other patients and healthcare workers.

It was at this point, as this row and the next row were appearing in the hospital, that it became obvious to the authorities that they had a serious problem on their hands and that illustrates part of the problem with this entire illness. One is looking at -- one û- one sees today not what happened today. What happened today, in fact, won't be seen for somewhere between a week and ten (10) days later.

34

When authorities and Public Health authorities recognized and hospital officials recognized they had a problem in the Scarborough Grace, at that point in time, and when we called the provincial emergency, we were dealing with an outbreak where we did not know for sure that it was a virus, we did not know for certainty what virus it was, we did not know what symptoms and what order of symptoms SARS presented with.

We had a vague idea that some of the symptoms might include fever and cough. We did not, for example, for some period of time, realize that about 30 percent of patients also could produce -- present with diarrhea. We did not know how long it incubated for. We did not know with certainty whether it was droplet spread or whether it was airborne. We did not know when it was infectious. We did not have a diagnostic û- diagnostic test for it and still do not have an accurate diagnostic test. We had no way of preventing it, we had no vaccine and we had no treatment.

What we had was an illness with many unknowns and virtually no knowns.

What we had then was only the tools that were available from fifty (50) to one hundred (100) years ago and those tools were to use isolation and isolation technique, and infection control meant to use quarantine and literally around the world as various people -- places such as Hong

Kong and Taiwan and Singapore and Vietnam and Toronto were facing this at the same time, we in fact, all reached for the same tools and all did the same things. We increased infection control and protection for people and we used quarantine.

Why was this a provincial emergency? It was my belief in advising the Premiere that there was a provincial emergency that we had a problem that we had few, if any, answers to and few, if any, solutions at present.

We had no idea at that point in time if or how to control with certainty the SARS outbreak. The scope of what was happening, in fact, was increasing. We were having more cases by the day, not fewer and there was no end in sight and that was the experience, in fact, at that point in time, in Hong Kong, in Taiwan and in Beijing, as it started, that it got bigger and bigger and no one was bringing it under control at that point in time.

As well, as I alluded to, what we faced, in fact, was what we saw today is what happened a week to ten (10) days ago, not what we were facing, in fact, in the future.

So in planning something and combating something like this, it's not like a forest fire which, in and by itself, can be difficult enough to control, but if I want to know the size of a forest fire, I can get above the

forest fire, see where it is and build a barrier so that the forest fire does not jump over that barrier and even if it does, I may be able to have a series of smaller fires I can put out.

The theory in controlling something like SARS is the same but the difficulty and the problem is, I have no idea where it is. I only know where it was ten (10) days ago and I have to not only catch up that ten (10) days, I must get further ahead.

And so, in my view, the only way of combatting something like this, is to go after it very hard and very fast and attempt to get far enough ahead that, in fact, if we have any breakout it's very limited.

Areas that did not do this at the beginning, such as Beijing, ended up with a much bigger outbreak because, in fact, that was the only way of getting in front of it.

The reality is that to manage something like this, it did involve multiple jurisdictions. It involved federal government, provincial government and the City of Toronto, York Region and the other neighbouring municipalities. We brought Toronto into the provincial operation centre and asked them to work directly with us.

We used the full resources of government and found, in fact, that we had many ministries involved. This

37

was not just a health breakout. This affected labour issues, education issues, social issues, economic issues, tourism issues, inter-governmental affairs, et cetera. It needed and received the full resources of the Ontario Government.

It involved multiple professions including paramedics, public health people, nurses, doctors and on and on the list goes. As I mentioned, it required bold and rapid action and we did attempt to be as coordinated and consistent in our approach as we could and I'll come back to that point.

And we did choose a system-wide approach because on the 26th of March, I knew that the hospital -- the Grace Hospital were affected. I had no idea that in those ten (10) days that it hadn't spread, in fact, into each and every hospital in the province and I certainly had no way of knowing which hospitals it would be in and which hospitals it would not be in.

And the logic and my thinking, at that point in time, in fact, was that we had to protect each and every hospital. If we didn't and we began to lose hospitals one after another, we would very quickly find we had large numbers of healthcare workers affected and we would have a healthcare system, in fact, that was simply unmanageable.

And we believed that what we did had to be done transparently. It's very easy today to explain what we did and how we did it and what we faced and we can do it from

38

the point of view and we are doing it from the point of view of building the system that we want to build for the future.

I hope we are successful. I want to have all of those tools to deal with in the future. I want a healthcare system that puts a premium on infection control, but, as I mentioned earlier, the system didn't and it didn't for good reason. We were spending our money in other -- on other things.

We have to look at what was done from the point of view of the reality of what we had to deal with. We did not have hospitals that were prepared for infection control. We did not have nurses and doctors who practised good infection control, who were used to getting in and out of gloves, who were used to -- and gowns and masks, who were used to working in these situations, who knew and thought infection control day in and day out.

We now are building a system that has to consider those things but it did not exist and our management and our decisions were based on what we knew and what we didn't know and how to make the system as safe as possible for everyone, including healthcare workers.

We had to balance, and did balance, and conscientiously made the decision to affect all of the hospitals in Ontario. We did not have infection control in any of the hospitals and we felt it was a priority to put it

in place before SARS showed up, not after SARS showed up.
As we had already learned with the Grace, after SARS shows up, it's too late. And if you can't tell which of the hospitals might be affected, and given our transfer system and given the way the province operates and the fact that we may have a, for example, a patient in Toronto General Hospital who's transferred back to Thunder Bay or some other hospital in the province, we haven't got time to figure out who all has been moved from what hospitals ten (10) days ago and we don't know which hospitals are affected.
Then the only safe thing to do is to put in place safety measures in all of the hospitals in order to protect everyone and be able to manage on an ongoing basis. We did that and we put the measures in place quickly outside of Toronto and reopened the system as quickly as we could.
We put stricter measures in place in Toronto where we had already recognized, in fact, that we had a larger number of cases and a larger number of hospitals that were effected.
We knew that we might potentially cancel elective surgery and put some people at risk. If we did not put infection control and medical education in place first, though, we faced the same prospect that Singapore faced, where they, in fact, got into a situation where they were

afraid their entire healthcare system would be closed as the infection spread from one (1) hospital to another hospital, and they were running out of hospitals that were unaffected and could continue to operate.
We recognized, in fact, that the beginning of an emergency is not smooth. It's a crisis, and in a crisis it's disordered. The idea of an emergency, in fact, is to return order to a situation that is not orderly. It is not -- crises are not happy times for people who like order in their lives.
It, by nature, means that we have to re-educate people and we knew, and you have heard reports and I have heard reports, about the fact that various hospitals interpreted things in various ways; brought things into being in different ways. We knew that there would be some people would -- who would accept the size and the magnitude of the crisis, we knew that others would not.
We knew there would be resistence in medical ranks, both in doctors and nurses and paramedics and anyone else, there would be those that saw the need and would -- would adopt û that there would be those that needed more education and would gradually come to understand the nature of what we faced.
We put in place, in fact, education to try to get people to understand the seriousness of the situation and

41

to understand how little we did know about SARS, and to turn the medical thinking into understanding that in fact SARS was a diagnosis of exclusion.

We had to assume that everyone with a fever and everyone who was sick had SARS and then exclude that afterwards and often that took days or weeks before serology testing actually told us whether or not they had SARS. In the meantime, that clearly meant then, unless we were sure that we had to protect other people.

We put infection control in place and we restricted the movement of people between hospitals and -û and who worked in hospitals. We discovered in the early days that there was a great deal of patient movement and, in fact, that patient movement proved, in fact, to have spread SARS to a large number of hospitals.

Within days, we recognized, in fact, that it wasn't just the Scarborough Grace Hospital that was affected, it was many other hospitals including the Sunnybrook Hospital, Scarborough -- Rouge Valley Centenary, Mount Sinai Hospital, York Central Hospital, St. Joseph's Hospital and the list goes on and we clearly recognize, in fact, that our concerns about it having been spread in fact had taken place.

We had to immediately put staff into gowns and gloves and masks and we chose, for means of protection, to use the û95 mask. We believed from the beginning that it was

42

droplet spread but we believed, until we were more certain, that we should use the more protective û95 mask. This posed problems for us because, in fact, hospitals didn't traditionally use large numbers of û95 masks and we scoured the world looking for û95 masks and trying to, in fact, supply the hospitals and doctors' offices with these things.

We clearly learned lessons out of this about inventory control on the future and maintaining supplies of infectious control materials, but that, again, in the world we lived in in those days, did not exist and we had to create those systems and create those systems for delivering supplies to doctors' offices. Those systems were simply not in place.

And we learned the hard lessons of the danger of someone who was highly infectious and having procedures such as intubation, when we had healthcare workers infected because of û- of intubations and, at that point, we sat for a weekend and re-wrote the guidelines and put healthcare workers into striker suits.

We used quarantine for the first time in fifty (50) years. It was one (1) of the only two (2) measures available: infection control and quarantine. It turned out, in retrospect, to be the least important of the two (2) but we did not know at the beginning, we did not know for several weeks, that it was not particularly communicable in the

community.

We suspected after a week or so that it was more of a hospital-based problem than a community-based problem but we could not be certain and we could not take the chance until we were more certain.

We had constant debates about the length of time for incubation -- for quarantine. We had constant debates about who should be quarantined and the procedures for deciding that became much more refined with time.

Toronto Public Health got very good, along with the infection control doctors, at figuring out much earlier who had SARS and who didn't and that was reflected in the fact that many fewer people needed to be quarantined as we went along.

But we have to remember there was huge public pressure for quarantine in some instances as well. I remember very vividly the debates that we had around schools and school closings and I remember Toronto Public Health advising that a very limited number of people at one school be quarantined and that the school remain open.

And I remember the public pressure to close that school just as an extra safety measure. So we cannot assume that just because we make a scientific decision that that's going to necessarily reflect the public's view or the public's concern.

As much as possible, we try to make the right decisions but there was public pressure, in fact, to do things very conservatively.

The whole world is studying quarantine now. I was in Washington at a meeting about quarantine a few weeks ago. I have meetings going into the Fall and the Winter about this. We recognize with the spread of infection, in fact, we may be back to a situation where quarantine is used in the future for SARS and for other illnesses and we are trying to learn the lessons.

Every country used quarantine, some much more than Ontario did. Some a little bit less, we were -- tended to be towards the middle and, as I say, we refined as we went along. But we cannot pretend there was no community spread. In fact, there was community spread and quarantine was serving a purpose.

We had community spread, in fact, through doctors' offices, with an incident in a funeral home and that, in turn, spread into a workplace. And we had it in a religious community and cases from there, in fact, spread to Montreal and to Philadelphia.

So we can't pretend that it was of no value or it didn't do anything. First, we didn't know it's value and secondly, there was community spread. We made the decision, from the beginning, as to what to do and how to do it using a

scientific committee.
The first night that we wrote the first set of directives, they were written by physicians, by myself and the physicians who were involved in the outbreak themselves and by Toronto Public Health. So they were written by the front line people who had the most knowledge, that night, about what to do.
They were written very quickly and they were revised as we went along but the idea of those was to put in place the biggest safety net as far as we could and I understand people who have not been used to this and have not practised in this environment finding them confusing and difficult.
I'm sure they were. We were changing things very quickly. But we did it on the basis of scientific information that was available to us that night. As we got through the outbreak, in fact, what we did was revise them as we got -- learned more information and as we became convinced that certain procedures or things were safe to do, then we would ease up on the directives.
The directives continued and continue to this day to be written by physicians and nurses who practise infection control, public health and there's as practical as we can try to draft them given the time lines we have.
In fact, we very often ran these directives by

hospitals and clinics and other groups. What we discovered, of course, was -- as with any directive is, the more we ran them by people, the slower they were to get out and the more we ran them by people, the more different opinions we got.
And medical people are famous for this. If you ask ten (10) of us our opinion, you'll get eleven (11) opinions and eventually we had to choose and we did the best we could to come down the middle but always have public protection.
Before you, you see the outbreak and the first case and you see the index people at the beginning, the Scarborough General outbreak, the point at which we recognized that things are getting worse and we declare the emergency.
You see the -- when we had to close the York Central Hospital a couple of days later and, in fact, all of that was already -- had happened.
The religious group, the infection of the hospital care workers over Easter weekend and in fact, the WHO advisory which came well after we already understood that we had the cluster underway.
What I would point out to you, Justice Campbell, is that, if you look at where the emergency was declared and you look at the cluster of cases around that, those cases, in fact, probably had already occurred as we

47

were declaring the emergency and so that group of people were already infected and the question or the issue was to stop the infection at that point and stop it from spreading and stop the graph from continuing to go upward.

At the end of SARS I, we had had twenty (20) days with no cases. The is the period the WHO were advising. We kept measures in place for longer than that and we continued to follow the cases in hospital very carefully. We were strongly focused on protection of the workers in hospital who were looking after the workers and we were continuing to screen for travel cases. What we had not counted on was that, somewhere in the system, that a case may be brewing and that had been missed.

We were not hearing, at that point in time, at the provincial level, about discussions or difficulties or potential cases in the system and that's very much to my regret.

In fact, clearly things were going on at that point, and I think it's a very important job of this Commission to hear from everyone and to be able to advise us as to what was going on and what likely did happen and how communications did break down at that point in time; allowing us to, in fact, learn more about this.

In SARS II, because we had infection control already in place, we did not have to shut the system down and

48

in an ideal world, we'll never have to shut it down again.

We now have directives, we now have ways of dealing with the system without shutting it down but in SARS I, we did not have that and so that meant in SARS II, in fact, that we were able to, in fact, bring the system into control very quickly.

And if you look at the graph, it was discovered around the 26th or the 27th of March, about halfway through there, that we had the second outbreak and again, just like the first outbreak, when the measures were put in place, the outbreak stopped.

So as soon as we re-applied the lessons learned from SARS I, we were able to control the outbreak. The issue, I think, for us, is not how to control the outbreak once it starts. We learned how to do that and we learned how to do that successfully.

The lesson or the challenge for us is how do we find the outbreak much sooner? How do we find the outbreak when we have one (1) case or two (2) cases, not when we have it breaking out as we did at the beginning of SARS I and at SARS II and the answer to that, in part, is surveillance and that's why with the blessing and the encouragement of the World Health Organization we, in fact, have been putting a great deal of effort into building a surveillance system for the fall.

The other answer clearly is clear communication within the hospital system and within the healthcare system and I again urge you to û- to address that issue as fully as you can.

I'm going to skip to the end of my remarks at this point in time, and just point out to you that the other countries that were involved in this, the earlier that people got involved, the harder hit they got.

It clearly was a hospital-based problem but we did not know that at the beginning and we learned that as we went along.

There were problems with secondary spread, not just in SARS II in Toronto, but in fact, if you look at the outbreaks, Hong Kong, Taiwan, Singapore all got secondary outbreaks. It just happened the secondary outbreaks were must closer to the first outbreaks and they didn't appear to be so far in distance, but the idea of missing a case and it springing up again existed in all of the outbreaks.

There was great public fear around the world and we did our very best to control this and I'm very proud of the job that, in fact, Ontario people did.

Our use of quarantine was unrefined because we had to teach people again and we knew very little about the disease at the beginning. We became more refined. The whole world's use of quarantine was unrefined. There were huge

economic costs to this and there were obviously strong public measures had to be taken in all countries.

Will SARS return? I hope not but there is risk and if not SARS there will be other infectious diseases that we face in the future. And so the lessons from this Commission clearly are applicable to everyone.

In summary then, I want to thank you, Justice Campbell, for allowing me to publicly express some of my thoughts. I'm confident that we will learn important lessons for the future from your work. SARS affected all of us, but especially those who contracted the disease, those that died and their families, and those who bravely faced SARS with all its unknowns on the front lines of medicine.

At great cost, we did manage to contain SARS. We did so by working together and doing the best we could. You do not manage and solve emergencies by assigning blame. You manage them by teamwork. Then, after the outbreak, you learn the important lessons so that future emergencies may be averted, lessened or managed more smoothly.

Our team consisted of front line workers, all of the ministries of government and, in particular, the Ministry of Health, public health units, paramedics. Everyone worked hard. They did their best. They gave of themselves and they all believe that this experience must be used to build a better system. I am very proud to be

associated with these professionals. Thank you.
MR. JUSTICE CAMPBELL: Thank you, Dr. Young. The next presenter is St. Michael's Hospital.
DR. JAMES YOUNG: Justice Campbell, just for the benefit of the press, I don't want to interrupt the presentation of the hospital and I'll be available then to the press during the break rather than interrupting in any way right now.
MR. JUSTICE CAMPBELL: Thank you.
MR. JEFFREY LOZON: Justice Campbell, thank you for this opportunity to present the learnings of the St. Michael's Hospital from SARS I and SARS II.
Our organization is well-known in Toronto and throughout the province. We are here to provide insights on behalf of our five thousand (5,000) staff members.
Collectively, my colleague Dr. Patricia Petryshen, Executive Vice President and Chief Nursing Officer, and I have extensive experience in major healthcare institutions across the country. I've been President and CEO of St. Michael's Hospital since 1992 and have served the Province as Deputy Minister of Health in the Province of Ontario.
Dr. Petryshen has been a leading nurse executive for more than twenty-five (25) years and holds a number of key provincial and national positions.

Notwithstanding our experience, the SARS crisis was our most trying test of leadership.
The uncertainty and newness of SARS, coupled with the intense fear and the anxiety that it provoked made this a unique challenge. We are relieved to report that during SARS I and SARS II there was no transmission of SARS from patient to patient, patient to staff, or staff to staff at St. Michael's Hospital.
We will begin and end our presentation with two (2) comprehensive recommendations and, in addition, we will relate the experiences of St. Michael's Hospital to provide a context for these recommendations.
Our recommendations are, emergency preparedness and system crisis management must be advanced at provincial level. There must be a coordinated plan for crisis response, strong central leadership and clear and timely provincial directives. Plan must be grounded in the over-arching guiding principle of patient and staff safety.
Second, healthcare resources must be protected during a crisis to ensure all patients have access to urgent and emergent care. The system should establish and appropriately resource designated facilities that could be marshalled in times of crisis to avoid closure of essential emergency services.
The two (2) SARS outbreaks were dramatically

different experiences at St. Michael's Hospital. During SARS I, we were a system resource for critically ill, non-SARS patients and treated a small number of SARS patients.

During SARS II we were an integral part of the SARS alliance, and accordingly experienced a significantly larger SARS caseload, coupled with reduced activity in other areas.

Both experiences were abided by a commitment to the highest levels of patient and staff safety regardless of cost. This commitment, and good fortune, allowed St. Michael's to come through the crisis without a single staff or patient transmission.

During SARS I, between March 9th and April 25th, St. Michael's had four (4) patients under investigation for SARS and two (2) probable cases. An additional a hundred and ninety-nine (199) patients were placed on contact and respiratory precautions. This latter group included patients transferred to St. Mike's from category 2 and category 3 hospitals for tertiary care.

Throughout SARS I, we were a category 1 hospital. Our role was to support this system by serving the acute care needs of our local community and, more importantly, St. Michael's continued to provide additional urgent and emergent cases, including cardiovascular surgery,

critical care and trauma, essential regional and provincial resources.

During SARS II, between May 23rd and June 30th, St. Michael's Hospital was asked by the Ministry of Health and Long Term Care to form a temporary alliance with three (3) community hospitals: North York General, Scarborough General and the Etobicoke site at the William Osler.

These hospitals cared for SARS patients from the community and those transferred from other organizations. Our role was to provide tertiary and quaternity care backup to these alliance hospitals.

St. Michael's Hospital cared for thirteen (13) patients under investigation four (4) suspect, and three (3) probable cases of SARS. An additional a hundred and seventy-eight (178) position -- patients were treated under respiratory and contact precautions.

During SARS II, we were category 2 and a category 1 hospital. Between May 23rd and June 4th, a hundred and ninety-one (191) staff and physicians were on a ten (10) day home or work quarantine as a result of exposure to SARS patients transferred from other facilities.

As previously noted, there was no transmission to our staff. Dr. Patricia will now speak about the experiences of our leadership and healthcare teams.

55

DR. PATRICIA PETRYSHEN: The first hint of impending crisis before the first provincial directive was received, our leadership team initiated a code orange, established a twenty-four (24) hour command center and moved immediately to a centralized decision-making structure.

The leadership team, which included all levels of hospital management, nursing and medical leadership, met two (2) or three (3) times each day for briefings to review directives, and to make critical decisions.

For example, it was quickly decided that the process for admitting emergent and urgent medical and surgical patients needed to be managed centrally by a dedicated team of doctors and nurses. Every decision made by the leadership team was guided by one principle; ensuring the safety of our patients and our staff.

Decisions and directions implementing -û implemented during SARS I, provided the foundation for how we handled SARS II. At all times during the SARS crisis, the leadership team was responsible for leading the operations of our entire hospital. However, during SARS II, as a designated tertiary site in the SARS alliance, our leadership team faced new and different challenges and so, to manage our role in the alliance, a different leadership structure was created.

Our CEO participated in daily conferences

56

calls with the Ministry and other alliance CEOs. The three (3) hospital executive vice-presidents were each accountable for one (1) of three (3) responsibilities: the command center, the SARS clinical operation and the urgent non-SARS clinical operation.

A multi-disciplinary decision-making structure included an oversight steering committee, a designated SARS management team and a designated SARS clinical team, all of which were supported by the use of databases to monitor SARS patients, staff exposures and mask fit testing.

St. Michael's was also responsible for working with the Ministry to co-ordinate the ordering and distribution of protective face masks on behalf of the East GTA hospital group.

With patient safety is a priority, St. Michel's consistently applied an evidence-based approach to decision making. Our SARS unit was managed as a closed system. We had twenty-one (21) dedicated negative pressure beds, of which five (5) were intensive care beds, sixteen (16) were acute medical and surgical beds.

Negative pressure beds, such as those designated for tuberculosis patients and our mental health unit, were deemed unsuitable for SARS patients. All SARS at risk patients were cared for by a designated healthcare team, regardless of the patient's location in the hospital.

57

I'd like to speak about our healthcare team. Never has the dedication of St. Michael's staff and physicians been as evident as it was during SARS crisis.

Despite many challenges and obstacles, our SARS clinical team came together to ensure the health and safety of our patients and each other. There are many experience to share; today we will touch upon a few.

Our infection prevention and control service team responded quickly and worked around the clock as a key hospital resource. Daily, the medical director of this team, participated in the command centre meetings to review directives and recommend the most effective ways to implement infection control practices.

The infection control practitioners worked with our healthcare workers and the designated SARS team to provide training and education, ensuring staff were competent in infection control. The infection prevention control service was successful in part because of the trust they established within the hospital community. They had high credibility, high visibility and an ability to act quickly to calm staff and physician anxiety.

Working closely with the medical director of the SARS infection prevention control services was the SARS medical director and the SARS nurse manager. During SARS II, their mandate was to create an enhanced care delivery model

58

that consisted of a multi-disciplinary team of experts with strong support from housekeeping and logistics.

Their role was to manage high patient volumes including screening, admitting to the twenty-one (21) negative pressure beds and repatriating patients to referring hospitals.

The SARS healthcare team was comprised of eighty-six (86) Registered Nurses trained in critical care, forty-nine (49) Registered Nurses trained in medical or surgical care and obstetrics, and forty-five (45) other healthcare professionals. Some of these individuals were assigned, while others volunteered for the SARS team.

In addition to coordinating the care of patients within the SARS unit, the medical director oversaw all patient transfers to and from St. Michael's hospital as part of a centralized decision making process. This meant daily updates from each medical, surgical, and intensive care unit.

The medical director engaged in frequent conference calls and discussions with the other alliance hospitals. The SARS medical director and SARS nurse manager took a central role supporting the SARS healthcare team by developing policies and processes for infection control, developing SARS-specific patient care procedures and by participating in infection control training sessions.

They were to answer questions from staff, physicians, patients, and family and to provide the support needed during this incredibly challenging experience.

The endless efforts of the SARS medical director, the SARS nurse manager and the infection and prevention control team ensured that the SARS healthcare team was well supported in the role for caring for patients.

The health and safety of our staff and physicians working on the SARS team was a priority for the hospital, resulting in the development of detailed policies and guidelines.

For example, because of the extensive protective clothing required when caring for SARS patients, every staff member on the SARS team was medically cleared by our employee health unit in accordance with the hospital's staffing requirements and infection control standards. This required staff to be fit tested for û95 masks to ensure full protection in the appropriate isolation clothing.

Education and training was also a priority. Staff on our SARS team were tested for competency with infection control techniques. They attended an orientation on their home unit and participated in one full day training to ensure they were competent in gowning and removing protective clothing.

The medical director and infection control

prevention team met regularly with the SARS team to ensure infection control standards were followed and to answer questions. Given the acuity of SARS patients, the cardiac arrest team received specific training for area management, emergencies, and cardiac arrests.

Physicians, Registered Nurses and respiratory care therapists on the cardiac arrest team received education on the donning of proper personal protective clothing including masks, goggles, foot covers, OR caps, gowns, gloves and additional protection called the personal protection system, such as the Striker T4.

The Striker T4 consisted of a helmet with a battery driven fan and a large protective toga with a clear visor that covered the helmet and the body. An electric fan was attached to the waist and another gown with an attached head cover to cover the entire body after which staff then again gloved. Getting in and out of this equipment was very complex.

In addition, gowning and de-gowning required monitoring by another staff member to watch for, and prevent against, breaks in infection control practice. An enhanced staffing model was also put in place to manage stress and fatigue.

Under normal circumstances, we have an intensive care staffing model of one (1) Registered Nurse per

61

patient. During SARS II this was increased to two (2) Registered Nurses per patient. With acute care medical and surgical beds, the staffing ratio was normally one (1) Registered Nurse for four (4) to five (5) patients.

During our SARS II, our ratio was one and a half (1 +) Registered Nurses per patient.

This model was created so that Registered Nurses did not work with a patient for more than one (1) hour at a time. Nurse fatigue, which could have led to potential breaks in infection control practice, was felt to be the greatest risk for SARS spread necessitating the need for this enhanced staffing model.

Among the broader community, staff cared for non-SARS patients and were provided with detailed policies and procedures and an extensive training manual. During SARS II, an education resource centre was established so staff could learn about SARS and recommend best practices.

The hospital also implemented a train the trainer approach to ensure that clinical staff received a review of infection and prevention control concepts related to droplet precaution, gowning, patient transport, oxygen therapy, body substance precautions, Code Blue and the personal protection system used in high risk situations.

As we noted, we are very fortunate to not have had any transmissions to SARS û of SARS to patients or staff.

62

We believe that this sound clinical practice was a critical factor and we commend our staff for their dedication to providing high quality care.

I'd like to just take a moment to share that during -- our patients during the SARS crisis were equally challenged, many of whom were frightened and isolated because visitor restrictions prevented them from seeing families and friends.

Nurses and physicians made an extra effort to fill this void while realising that patient safety always was paramount important.

St. Michael's is an inner-city hospital that treats a diverse population of many cultural and socio-economic backgrounds. Our patients have complex care and communication needs. To illustrate, fifty-one (51) of the patients under surveillance in SARS I and SARS II, were homeless or from a shelter.

When these patients came to our hospital, with either respiratory illness or fever, they were admitted and kept until discharge and when appropriate given -- and when appropriate they were kept because many of our community shelters did not have adequate resources for isolation.

Nor was there a quarantine plan in place to deal with potentially disastrous outbreaks in the SARS hostel -- SARS in the hostel system.

Ensuring patient safety required an educational component as well. A special SARS discharge clinic was established with a designated healthcare team. These Registered Nurses took extra time with discharging patients to carefully explain precautionary home quarantine instructions.

Throughout our healthcare team -- throughout this entire time, our healthcare team took extra time to do whatever was necessary to ensure patient safety. The genuine outpouring of affection and concern for our patients was incredible to witness. And so I would like to, now, pass this back to Jeff Lozon who will talk about some of the challenges we faced.

MR. JEFFREY LOZON: First, let me state that while we are proud of our approach, our contribution and our record, it did not come without enormous personal sacrifice, particularly amongst our front line care providers.

SARS was a period of intense uncertainty and fear unparalleled in our healthcare experience. Perhaps the first lesson is that the clarity of action, clarity of decision making structures, commitment to high level principles and constant communication are indispensable during times of crisis.

St. Michael's Hospital was challenged to understand and implement provincial directives in a manner

that would ensure patient and staff safety and excellent patient care. It was difficult to obtain clarify about specifics on a timely basis. Further, the time needed to digest and understand these provincial directives and to develop operational policies to guide practice was not always available.

Another critical challenge is providing real time information in a number of SARS patients at St. Michael's Hospital, bed availability and supplies.

Supplies were particularly problematic as there is not enough masks available in the system for optimal safety. After fit testing having supplied the right type of mask for the right staff member complicated the issue. The requirement for mask fit testing was a significant challenge. St. Michael's Hospital went to great lengths to comply with provincial directives with respect to fit testing.

However, constantly changing directives and the demands of managing the crisis at hand, made fit testing a very complex undertaking. When a staff or physician failed the fit test an alternative mask was not always available. This created a situation in which individuals could not work in areas where an û95 mask was mandatory.

For example, in our emergency department at one time, approximately 30 percent of the registered nurses had failed fit testing. In addition, on a daily basis, we

were challenged with the fact that adequate supplies of fit tested masks were uncertain.

A priority throughout SARS was to ensure the protection of our patients while continuing to treat our most acute cases. Life threatening illnesses, such as patients with renal disease were always accommodated, there was restricted access to other non-emergent services. This resulted in the cancellation of non-essential activities.

For example, the cancellation of chemotherapy for oncology patients. Patients requiring interventional procedures were delayed. This resulted in a further delay for new consultations, cancellation of investigations, and procedures.

Another challenge was to manage the reality that many of our healthcare professionals, including physicians, work at more than one (1) organization. Knowing which staff work at other organizations requires staff consent and a very sophisticated tracking system.

Human resource approaches need to be developed to address the reality that healthcare staff and physicians work in many settings in many different roles. We will never be able to sustain or finance a one-staff, one-site model. However, the need to co-ordinate resources across the system is essential.

In a time of crisis, the system needs to

function so access to all levels of care is readily available. An oversight body is critical to ensure all organizations support each other's patient bed requirements.

For example, the need to move patients to an alternate level of care facility was extremely important. This was eventually very well done during SARS.

Throughout the SARS experience we learned that the healthcare system has minimal capacity to absorb increased care demands. You simply cannot operate the system over-capacity on a routine basis. This has become very apparent during the SARS crisis, especially when enhanced and dedicated staffing models and management teams were essential.

For organizations to provide tertiary and quaternary care, trauma services, and to deal with situations such as staff on home or work quarantine, was an enormous strain. SARS II forced us to close units which impeded our ability to have a fully functioning emergency department and critical care unit.

At St. Michael's during SARS II, to enhance patient and staff safety, it was necessary for us to close twenty-eight (28) critical care beds to have adequate nurse staffing ratios. We did not have the human resource capacity to staff both SARS beds and our critical care units.

As a result, during SARS II, our hospital was

essentially closed to critical and trauma and neuro-surgery, cardio-vascular surgery, and vascular surgery.

St. Michael's Hospital is key provider in the delivery of tertiary services, and so to close it's operations because of staff shortages puts an enormous strain on the rest of the system.

Finally, we believe that the alliance approach in SARS I, while conceptually a better approach, had some shortcomings. First we were trying to set up an alliance in the midst of a crisis. Secondly, members of the alliance were at different stages of involvement, and the actual role of alliance hospitals was not understood by the broader system.

We feel strongly that an alliance cannot afford a tertiary resource like St. Michael's Hospital. Not because of the actual cost it took, but rather because of the many resources that come out of this system when we fill a SARS role.

Having said this, as an alliance hospital we received active support from the Ministry of Health and from our other colleague hospitals. As well, many of the policies in SARS II are a major step forward from SARS I.

In summary, we would like to provide two (2) recommendations for policy directions.

First, emergency preparedness and system

crisis management must be advanced to a provincial level. There must a coordinated plan and strong sense of leadership. This plan must be grounded in the over-arching guiding principle of patient and staff safety.

A disaster response model must be developed to better manage and integrate the various diverse sectors and demands of the healthcare system. This model must include a Ministry appointed centralized authority to provide leadership, strong direction, coordination and timely response are essential.

Specific roles must be assigned and well understood before the crisis, and adequate support for these roles must be available.

An effective disaster response model needs to designate facilities for use in the time of future crisis. These facilities must be effectively resourced and their staff trained and knowledgeable.

The safety of our patients and staff during SARS crisis became -- requires clear and timely provincial directives and an enhanced SARS care delivery model.

Secondly, healthcare resources must be protected during a crisis to ensure that all patients have access to emergency and urgent care. The system should establish and appropriately resource designated facilities that could be marshalled to respond in a future system crisis

to avoid closure of essential emergency services.

Justice Campbell, there are many more lessons to be drawn from the SARS experience. These lessons are at the federal, provincial, and institutional level. We look forward to continuing to add our views to this body of work so that we may help to improve this system's crisis response capacity to build upon the successes we have achieved. Thank you.

MR. JUSTICE CAMPBELL: Thank you for your presentation. It's just a little bit after 11:30, we'll take a break for fifteen (15) minutes.

--- Upon Recessing at 11:32 a.m.
--- Upon resuming at 11:52 a.m.

MR. JUSTICE CAMPBELL: Our next presenters are two (2) gentlemen who are front line workers for the Canadian Customs and Excise Service.

MR. EMERSON WAUGH: Good morning, Mr. Chair, first, I'd like to introduce myself. My name is Emerson Waugh, I'm the Branch President for the Customs Excise Union in Toronto and I represent -- I'm also the Occupational Safety and Health Labour Code Chair representing Customs Officers and employees of Canada Customs and Revenue Agency.

To my right we have Mr. John King. He's our

first National Vice President of the Customs and Excise Union and he's also our national representative on the Occupational Safety and Health.

I'd like to start by saying thank you for permitting us the opportunity to speak to you here today. Before we begin we wish to extend our sincerest sympathies to all the people and their families who were affected by the SARS outbreak, especially those who lost a loved one as a result of this horrific disease.

We are here today to offer you a perspective that has not been given the same attention as that given to emergency medical services and other emergency organizations.

While we certainly recognize these fine people as first responders during this emergency, there is one (1) fact that has escaped many, that is they weren't the first to encounter this disease in Canada.

In fact, the first encounter occurred when one (1) of our members, a fellow customs officer, processed a female traveller entering the country. This traveller subsequently succumbed to the effects of SARS and died.

The litany of errors that occurred as a result caused much concern within my organization. Concerns that have been expressed in the past and concerns that exist today. SARS, as we know it, may have been eliminated, for now at least, but SARS isn't the only problem.

71

The problem is the vulnerability of our nation and its citizens to incoming disease, et cetera, carried by innocent travellers. Poor communication, a lack of adequate protective equipment for front line personnel, slow response to this emergency and a desire not to give the impression of a potential threat to members of the public did nothing to alleviate the risks faced by travellers, members of the public or the various persons employed to deal with them.

The level of ability and skill required to assess a person's physical well-being does not exist within the Customs organization. The people employed to guard your borders are not medically trained or certified to the extent necessary nor do the tools exist to permit them to do so. It has been stated and recognized that the symptoms caused by the SARS virus are similar in nature to a cold or flu, symptoms that can be hidden by the use of common, over-the-counter remedies available at a pharmacy.

There has been little or no change in the manner in which our members deal with the travelling public. We are of the opinion that the risks that existed and the flaws in communication still exist today.

The screening tools that have been put in place by Health Canada are virtually useless. This relying on the travelling public to self-diagnose or self-identify as at-risk is a poor method of control.

72

Imagine being a traveller returning home to Canada who may have been exposed to a disease such as SARS while outside Canada who is now facing the prospect of possible lengthy quarantine, et cetera. How many, thinking they just have a cold or the flu, would volunteer information especially when they do not believe they have SARS?

Now imagine the possible consequences for the person processing this traveller who, because the traveller doesn't show obvious symptoms, doesn't take the necessary precautions to prevent disease transmission. They put themselves at risk, as well as their co-workers, their families and other travellers who they deal with subsequent to the initial encounter.

Denial seemed to be the norm and denial continues to be so. After all, look at the comment made by Premier -- the Premier of Alberta regarding BSE. Whether intentional or not, he suggested it would have been better to hide the single case of BSE in order to prevent the negative effects of mad cow disease on the economy of his province and the country.

The impact of SARS clearly showed the same effect. The consequences of any similar epidemic, should one occur, would be equal, if not greater. The priority that we experienced in CCRA seemed to be the speedy movement of goods and travellers, dollars versus lives.

An ounce of prevention is worth a pound of cure. The one case that made it through Customs and was not properly diagnosed, identified, and referred to the proper medical authorities led to a litany of errors, to deaths, to illnesses and had a major impact on our community. There's nothing changed.

We were told in our own environment that masks weren't really necessary, the risks were minimal. It's unknown, we don't know what the problem is but instead of taking the high road and actually dealing with it in a more aggressive, proactive manner, we were told just to -- we -- our national representatives were actually told, you know, we don't want a negative public impression. We don't want to look bad. The image of masks being worn by front line personnel processing travellers might give a negative impression.

The effect that this had on the people that I deal with, that Mr. King deals with, on a day-by-day basis, the fears their families had to go through, the knowledge that the officer who had dealt with the first traveller, to know that he was potentially exposed but to know that had he maybe intervened if he had have seen a sign, a symptom, may have saved a life, may have stopped the epidemic that occurred, that has to weigh on people's minds.

We told management, CCR representatives, a

long time ago that we needed better, adequate protective equipment, quarantine protocols, training to deal with possible diseases. We've experienced Ebola, Legionnaires' Disease, Tuberculosis, to name a few and we've told them time and time again, we need the equipment, we need the training, we need the skills and ability.

A thermal camera stationed somewhere to record someone's body temperature when they can take an aspirin an - - and have that down -- reduced, to have someone fill out a form that says; have I been exposed -- well, I'm not going to tell you, quite honestly. If I want in the country, for whatever reasons, I'm not going to tell you.

To say that people who handle those individuals are at low risk when they have intimate contact with the individuals going through personal belongings when we didn't know how long the virus existed on inanimate objects, there were a lot of risks that people allowed others to take and they should never have done so.

I can't offer solutions. It's not my area of expertise. I am simply offering a perspective that may have not received the level of consideration that it needed to do a post mortem on SARS.

We're here because we know that a point of vulnerability is that person coming in with that disease and if we don't see it, they're coming in. They will be allowed

access to the community at large and we will lose track of them.

That was identified in the length of time it took us even to locate which officer dealt with that first traveller. We didn't know. That's an undue delay when you're looking at something that spread as quickly and as significantly as this virus, a day, two (2), three (3), it's not appropriate.

I wish I had answers for you. All I can do is to provide the commission here the concerns and the desire of the members that we represent to do the best they can to protect the citizens of Canada of the Province of Toronto. We want to be there to help but we weren't given much consideration. We didn't have the tools.

In fact, my local, the local I represent, I had to go out and buy û95 masks, to give to my members because the employer wouldn't. That's the attitude that we have to defeat overall. That's what needs to come out. Because if we can stop it there, we û- we -- the û- the dollars spent are more wisely spent there than they are setting up even this Inquiry.

If you have any questions, we'd be more than happy later on.

MR. JUSTICE CAMPBELL: Well, thank you very much. We may follow up with you later on with some of those

details. Thank you for your presentation.

MR. EMERSON WAUGH: Thank you.

MR. JUSTICE CAMPBELL: Is the Canadian Union of Public Employees ready to go, CUPE?

MR. BRIAN O'KEEFE: Good morning, Justice Campbell. We really appreciate this opportunity to present here this morning. My name is Brian O'Keefe, I'm the Secretary Treasurer of CUPE Ontario and we have with us here this morning a representative from our Airline Division, France Pelletier, who's the Legislative and Regulative Affairs Officer.

I've got Michael Hurley who's first Vice President of CUPE Ontario and also the President of the Ontario Council of Hospital Unions with us and also I have Mark Ferguson who's a paramedic with the City of Toronto and a member of the Executive Board of CUPE Local 416.

We also had Fred Taylor from Local 79 who's a public health inspector. We expected him to be with us today but, unfortunately, he's detained in hospital and unable to be with us -- oh, sorry. He is here. I didn't realize he was here.

The Canadian Union of Public Employees is the largest union in Canada. We represent over five hundred thousand (500,000) members across the country. Two hundred thousand (200,000) of them in Ontario. In the healthcare

sector we represent fifty thousand (50,000) workers. They work in hospitals, homes for the aged, nursing homes, in the ambulance sector. We represent three thousand (3,000) paramedics across the Province of Ontario.

Also, we represent workers in the community care sector who work for CCACs and those agencies who are contracted by CCACs to do work in the community and we also represent public health inspectors, public health departments in the municipal sector and numerous other ancillary workers who work in the healthcare field.

In addition to that, we represent workers in social services, municipalities, universities, school boards in addition to utilities and libraries.

As front line providers, we feel that we are well-positioned to respond to the SARS outbreak and also the response to the SARS outbreak -- or, at least, the immediate response and also on the steps that are being taken to rectify the situation.

And I want to remind you that we have -- we had members that were seriously impacted by this disease. Many -- hundreds of our members were in quarantine but also we had ten (10) hospital workers who contracted the disease and also four (4) paramedics.

As front line providers, we can attest to the chaos and confusion that existed out there right throughout

this outbreak and also we can -- we're well placed to comment on the lack of resources, the lack of planning that we saw out there.

We saw quite clearly that there was very little cushion in the system and governments and employers systematically ignored the advice of our members right throughout this outbreak. Such an outbreak, we feel, was inevitable depending on the huge lack of resources in the healthcare system over the last number of years.

And, regrettably, we see little that's out there right now that's being seriously done to rectify this appalling situation.

And I'm going to call upon -- we've broken this down into a number of different sections and I'm going to call upon Mark Ferguson to talk about the situation with ambulance workers.

MR. MARK FERGUSON: Thank you, Commissioner Campbell. I would like to start off by taking the opportunity to acknowledge the heroic efforts undertaken by the paramedics in Toronto and across the province in assisting to prevent the spread of this deadly disease.

Three (3) CUPE paramedics became infected with SARS during the course of performing their duties. A fourth contracted it after being directed by his employer to report to hospital and being placed directly in a room next to a

person with SARS.
Hundreds of paramedics and well over -- hundreds of paramedics were quarantined and well over a thousand (1,000) were exposed -- potentially exposed to this virus.
In our private lives the community reacted to paramedics with fear. We continue to have considerable fear that SARS or other infectious diseases will strike again and force ourselves and our patients to relive a very ugly experience.
Chaos and confusion mark much of the response to the outbreak and inconsistencies were widespread. Front line paramedics were endangered. For example, there was a lack of direction and personal protective equipment for intubating patients in a pre-hospital environment. This continued even after direction had been given for intubation in hospital. Indeed, there -- this lack of direction for intubation continued well into May.
Further, while staff working in hospital with SARS patients were directed to wear positive pressure suits while intubating, paramedics were not afforded this protection. This inequity has put paramedics and the public at risk.
The province indicated that we should have followed an infection control manual but paramedics in the

centre of this outbreak did not see this manual until well into the crisis.
Paramedics discovered in the midst of the crisis that a common ambulance cleaning disinfectant Hydrox did not have any viricide (phonetic) capabilities. Likewise, there was the delay and confusion regarding the fit testing of masks.
Fit testing did not commence well until -- well into July. In York it took considerable time to get disposal bag mouth masks. In the north and other parts of the province it took a long time just to get the û95 respirators.
Indeed, there was a constant problem with acquiring sufficient protective materials. There was a lack of personal protective equipment and training. Generally, infection control procedures were weak.
The willingness of employers to involve paramedics in developing a response to the outbreak varied. Too often, front line paramedics were not involved in the central command and we were unable to get health and safety committee meetings up and running.
In York, paramedics often had to rely on the information provided by paramedics in the City of Toronto.
In the City of Toronto front line paramedics were closely involved with developing an effective response

and set up a desk in the command centre which we were able to communicate with Union Stewards and other front line paramedics.

This improved our response to SARS. This allowed the union to immediately pursue problems, address membership issues and help bolster the confidence of paramedics on the front line in the fight against SARS.

With the cutback of hospital beds and resources stretched to the limit, there has been a long-standing problem in Toronto hospitals with wait times in emergency rooms. So much so that Toronto emergency medical services has recently devised a new system for leaving patients in hospitals to ensure that ambulance paramedics can return to service in a reasonable amount of time.

As a result, during the outbreak it was not uncommon for paramedics to be required to wait for hours on end in their ambulance with suspected SARS patients before being allowed to take these patients into the emergency departments.

Indeed, paramedics were often redirected from hospitals unwilling to accept a suspected SARS patient. We are not convinced that the necessary improvements that are required in infection control have been made since the outbreak. Indeed, some negative practices are deepening.

During the outbreak, Health Minister, Tony

Clement, raised concerns about moving patients from one hospital to another. This is a valid concern. Transfers between healthcare facilities have a great potential to spread the infectious disease and with hospital restructuring this is an expanding industry.

Five (5) years ago, trained paramedics would have done most of these transfers. Now, fewer and fewer are done by paramedics and more work is handed over to for-profit transfer services. These transfer services are not regulated and the drivers are not paramedics. Their wages are much lower. Is this adequate? We are concerned about this new emerging standard. Thank you.

MR. BRIAN O'KEEFE: I'm now going to call upon France Pelletier from the CUPE Airline Division to talk about our experience in the airline industry.

MS. FRANCE PELLETIER: Good afternoon. SARS was spread to Canada through international air travel and yet our airlines were reluctant to take full necessary steps to protect flight attendants and passengers during this SARS outbreak.

Flight attendants were forced to deal with the lack of contingency planning by the airlines for the spread of infectious diseases through air travel. At first, there was no plan to disinfect planes after travel by an individual with a suspected case of SARS.

When a procedure was eventually put in place, it was inadequate. There was no plan on how to deal with discharged SARS patient. We received no medical clearance for these passengers. Flight attendants were advised by Health Canada that there were probable contacts with SARS passengers were never quarantined.

Work refusals occurred because carriers continued to fly in SARS affected areas without providing personal protective equipment. There was inadequate protection for flight attendants. There were significant employer restrictions on the use of protective equipment for the flight attendants in order not to alarm the patients even though we handle their used napkins and tissues and utensils and pillows and blankets.

At Air Canada the union requested protective gear and disinfection of aeroplanes after flights carrying suspected passengers with SARS.

The union, finally, actually, purchased gloves and masks for our flight attendants but Air Canada initially banned flight attendants from using them, generally, except in specific cases of handling sick passengers and for cleaning the bathroom. We were stopped from distributing masks and gloves to our flight attendants.

To add insult to injury, at the conclusion of flights from areas affected by SARS, flight attendants would

openly clean the aircraft doors to see airplane cleaning staff in full protection suits. The flight attendants who had been confined to a small space for fourteen (14) hours could not even wear masks or gloves without fear of facing discipline from their employer.

Staff who did not deal directly with the public, however, were under no such direction.

The airlines were often -- all too often more concerned with image than safety. We believe that the passengers would have felt safer if they saw the airlines taking pro-active steps to prevent contagion.

To help remedy this problem, the union filed a complaint against the airline with a government safety officer for Human Resources Development Canada.

Air Canada was trying to get out of its responsibilities and we had to push them to the wall. Eventually, Air Canada was required to perform a risk assessment that indicated there was little contingency planning and the most -- that the flights that were most dangerous in -- in --in the sense of possible exposure were the domestic flights.

It was the responsibility of airlines to have a contingency plan for staff who may in -- be infected or quarantined in a foreign country. However, no such contingency plan yet exists.

Finally, we have seen little, if any, improvement in infection control preparedness at our major airlines. In light of TorontoÆs strong -- in -- in light of Ontario's strong international links, we must expect that a future SARS outbreak may spread in this manner and that Toronto's Pearson airport will be at the forefront of such outbreaks.

We saw little evidence of co-ordination between provincial and federal government concerning the screening of passengers. Indeed, even today, the political squabbles continue and no satisfactory system is in place. Thank you.

MR. BRIAN O'KEEFE: I'm now going to call upon Fred Taylor to address the situation with Municipal Health Departments.

MR. FRED TAYLOR: Hi. My name is Fred Taylor, I'm with local 79, I'm the Health and Safety Rep. Anyways weÆre going to talk about the municipal -- what happened in the municipalities.

In addition to paramedics, hundreds of other city of Toronto employees were part of the city's response to SARS and these were represented by local 79, the city's inside workers.

The Department of Public Health staff worked on the SARS hotline in the case management and contact

follow-up and in epidemiology. Other city staff worked with public and dental clinics and social services and in the buildings inspection and more. These inside workers did not enjoy consultation and co-operation from management at the city of Toronto.

Their concerns for their own health and safety, as well as the health and safety of the public they worked with, were routinely rebuffed. Their requests for personal protective equipment were ignored, even when their jobs entailed contact with members of the public in quarantine, or screening members of the public for SARS.

Their attempts to hold joint health and safety committee meetings were stymied. Municipal public health departments are operating with few reserves; when the SARS outbreak occurred, workers were pulled off other vital public health duties.

Food, meat and restaurant inspection were drastically reduced. Immunization, pre-natal nutrition, healthy heart programs and food handling training were cancelled.

The well-baby program was severely curtailed and most other department public health programs were reduced to high risk cases only. Some programs remained closed over the summer to make up for the some of the department's additional spending on SARS.

87

We were lucky in this cost no significant health problems. None of the three (3)levels of government had a computerized disease tracking system adequate for the SARS outbreak. Much of the time the public health workers was spent in the complex paper tracking procedures.

Municipal homes for age were hard-hit by requirements that part time workers could only work at two (2) sites or, in case of some city-run homes, one (1) site. In one (1) home, for example, thirty-nine (39) of forty-three (43) part time CUPE workers, worked at more than one (1) healthcare facility in order to make ends meet. Thank you.

MR. BRIAN O'KEEFE: I'm now going to call upon Michael Hurley. He's going to deal with three (3) issues. He's going to deal with the hospital sector also the -- putting economic interests against -- as opposed to the health and safety of the workers in the system and also the lack of resources in the healthcare system in Ontario.

MR. MICHAEL HURLEY: Thank you, Commissioner Campbell. CUPE represents nurses, cleaners, maintenance and other staff in Ontario hospitals. About twenty thousand (20,000) members at sixty (60) public hospitals. Ten (10) of our members contracted SARS. One (1) of our members brought SARS home and infected her two (2) twin children. Happily all of those workers have recovered.

CUPE participated in daily calls with the

88

Ministry of Health, the Ministry of Labour, the Ontario Hospital Association, the Service Employees International Union, Ontario Nurses Association and other unions to talk about SARS, the outbreak in the hospitals, and what our views were about it.

My personal view, as a participant in those calls, is that we were almost completely unable to influence government policy with respect to SARS. The unions repeatedly raised concerns. Were the precautions that we were being advised -- were adequate, were they, in fact, adequate?

For example, the Û95 mask ,which, only screens out -- doesn't screen out 100 percent of -- of particulates didn't appear to us to be the kind of barrier that would obstruct this virus, let alone the problem that the masks were distributed without fit testing, which only happened much, much later in the outbreak.

In other jurisdictions, for example in China, workers were not allowed into patient care areas without wearing full suits with respirators, but those suits emerged only late in the outbreak in Ontario as though we were a developing country, and it wasn't the other way around.

Some hospitals gave out surgical masks which were known not to obstruct the virus and gave those to workers. Some hospitals would not give workers masks at all

89

and those issues were raised by us, not with much success.

We raised concerns about whether the SARS virus could potentially be airborne because in the Lea Gardens (phonetic) complex in Hong Kong, although people were quarantined, the virus was moving vertically in the building and infecting people.

And we heard from the government scientific committee that it was not airborne and we shouldn't worry about that and, frankly, I wonder on what scientific basis they could come so quickly to that conclusion and, in my estimation, they were way, way too definitive and we should have been erring -- we should have been operating as though SARS was an airborne virus and the precautions taken accordingly.

Screening varied widely from hospital to hospital. Some hospitals screened people coming in with signs posted on the door in English, ignoring the fact that large percentages of the population can't read or can't read in English. And other hospitals had full screening in operation so the precautions varied widely.

The unions asked the provincial government to order that pregnant employees be removed from potential exposure to SARS because we knew that the drugs used to treat SARS killed the fetus. Despite that, the government was unable and unwilling to issue any such edict, even though 85

90

percent of the hospital workforce is women -- is comprised of women.

We asked the government if they could order that joint occupational health and safety committees should be involved, because, given the hierarchical and undemocratic nature of hospital decision making, you've heard a lot about leadership teams here this morning, but in terms of mobilising the nursing, building maintenance, cleaning, infection control skills of the hospital workforce, oftentimes, we were standing with our nose pressed to the glass unable to contribute our skills in the mobilization against SARS. And that was criminally stupid and the government would not issue any -- any order to hospitals nor would the Ministry of Labour to compel employers to involve their workers.

But they could issue an order that restricted the ability of workers to work at only one (1) site during the outbreak. An order that they subsequently had to rescind and this intrusion into the labour market, that, and their paying premium pay to selected nurses at selected facilities, created these warps in our internal industry labour market where, now, workers were focused on, hey, how do I get paid a hundred dollars ($100) an hour to deal with SARS?, instead of focusing on; are the precautions adequate; am I safe at work, which is what the province should have been paying attention

91

to.

And I'd also like to suggest that when the Ministry of Health said we had to redefine our approach to SARS and we had to learn to live with SARS and -- and the new normal that he was responding to pressure -- economic pressure from business in this -- in this province, pressure from the doctors whose out patient elective surgeries had been cancelled as a result of the outbreak, pressure to start the operation quickly and without necessarily due regard to what impact that would have in terms of exposing the public once again to SARS. This hospital system was told to ramp down its precautions, which it did, and there was a second outbreak and why was that?

Can you imagine in the middle ages if we were dealing with Bubonic Plague that people would be going around talking about; hey let's define -- let's redefine what's normal and let's learn to live with Bubonic Plague or E-bola virus. Unbelievable but -- but in Ontario, that's what happened.

So I would just like to -- like to say, Commissioner Campbell, that our experience was that if Ontario survived in the hospital system through SARS it -- it was blind luck and the incredible compassion that people brought to their jobs, the paramedics and the people who worked in the system, but it had very little to thank, either

92

the scientific committee, the central coordinating committee or the Ministry of Health in terms of their contributions around those issues.

The healthcare system has been de-funded and certainly the hospital system was close to -- close to collapse at certain points during this crisis as hospitals were closed and those hospitals were removed from the system.

There have been huge bed cuts, eighteen thousand (18,000) bed cuts and you could feel that in terms of -- of the ability to deliver hospital services during the crisis and we can't ignore the fact that -- that those bed cuts have brought the system so close that it has absolutely no ability to cope with -- with this kind of an outbreak and that's something that you need to turn your mind to and also, you know, despite the fact that much was written about infection control, and that actually, it's fairly straightforward that surfaces in hospitals have to be cleaned and, the fact that, a virus could live for such a long time on surfaces at the North York General Hospital leads you to conclude that, perhaps, it's not cleaned as well as it might be.

The lack of attention to that kind of essential detail has hurt -- has hurt our ability to fight SARS. In addition to all of the mobilization of medical and

scientific resources, there also has to be attention to whether the facilities are adequately cleaned; and they have not been -- often the cleaning staff has been dessimated through layoffs, sometimes even contracted out and -- and paid very little to do a job with high rates of turnover which, in Taiwan and other jurisdictions, they've pointed to as being one (1) avenue that SARS entered the hospitals and we've provided you with information in our brief.

So these are also fundamental issues that need to be addressed in terms of dealing with SARS. Thank you.

MR. BRIAN O'KEEFE: Some concluding remarks around what is actually being done about the situation. We feel that the response so far has been very little. Not only that, in fact, we see that some of the actions of the provincial government are actually made it -- making things worse. We agree with the government that there's a lack of reserves in the system, there's very little cushion.

We also agree that there's not enough front-line workers -- full time workers and there needs to be more -- more full time workers as opposed to casuals and part-timers and we also need -- we concur with the provincial government or the Ministry of Health statement that -- that infection control needs to be stepped but if I could -- Michael Hurley has alluded to it already, but there -- there has been a severe cutback in cleaning services in hospitals

over the last number of years and the Canadian Institute of Health Information has indicated that on an average annual basis over the last -- over the last -- the second half of the 1990's, housekeeping has been cut on an average annual basis at 1.8 percent. And also the laundry services have been cut by 5.4 percent on an average annual basis.

And here, again, we want to bring to your attention the differentiation between clinical and non-clinical services. We feel that those non-clinical services are absolutely vital to infection control in the healthcare system.

And also we pointed this out to you before, that the whole trust of privatization in the healthcare system, the push towards P3 (phonetic) hospitals. All the evidence is out there from the Auditor General in Scotland, the -- the National Health System in the UK, there's an appalling record around what's happening to support services, particularly cleaning services and the important that has for infection control.

And Michael has already mentioned about the Taiwan situation and the -- the Centre for Disease Control in Taiwan, they've clearly stated that a big part of the -- the outbreak in Taiwan related to inadequate cleaning in the -- in the system.

So, those points are really important. Also

we see very little evidence of additional resources going into -- into the system to address some of those huge bed shortages and the back up in the system and I've already mentioned the issue of full-time workers. We see that as a major issue.

In conclusion, I just want to point out that we are not ready, at this particular point in time, to give you detailed recommendations. We need further consultation with our front line people in order to give you detailed, comprehensive recommendations but the themes that we've advanced here this morning, the total lack of the respect for the workers in the system, the fact that health and safety committees didn't meet on a regular basis and when they did meet they were ineffective.

Also the fact that the advice of workers was not heeded. That's the first point. The second point is the totally inconsistent implementation of infection control. The use of gloves and gowns, all that kind of stuff, it varied enormously from one place to another and was totally ineffective.

Then the point that economic interests were put above the health and safety of the workers in the system. The -- Michael has addressed the huge lack of resources in the system and, finally, we feel that the current response is pretty pathetic and, in actual fact, is making things worse.

So, in the course of time, we will be very pleased to give you a full set of recommendations around all those issues. Thank you very much for giving us the time to present to you this morning.

MR. JUSTICE CAMPBELL: Thank you for your presentation. I look forward to your detailed recommendations.

The next presenter is the Service Employees International Union.

MS. SHARLEEN STEWART: Good afternoon. My name is Sharleen Stewart. I'm the Canadian International Vice President for Service Employees International Union in Canada, and with me today is Ross Ann Clarke, an SEIU Steward and co-chair of the Health and Safety Committee of the North York General Hospital here, in Toronto.

As well, John Van Beek, from Local 204 and I also have Ted Mansell, here, who is the Health and Safety National Coordinator from SEIU Canada.

SEIU Canada represents ninety thousand (90,000) members across Canada. We are part of Service Employees International Union which has 1.6 million members in healthcare and related industries across North America.

In Toronto, SEIU represents hospital workers at Sunnybrook Women's College, St. Michael's, Mount Sinai, Princess Margaret, North York General, Toronto East General,

97

Humber River Regional Hospital, William Osler, Toronto General, Baycrest, Runnymede Chronic Care Hospital and West Park Hospital.

In addition, our members also work in nursing homes, retirement homes, home care and community living settings. I mention these facilities because as Registered Practical Nurses, environmental and housekeeping staff, clerical workers, dietary personnel, technicians and skilled trade workers, we have been the forgotten healthcare workers, simply because the healthcare system doesn't value the work our members do.

They are not needed as -- they are not deemed as important as those who provide direct patient care aid -- or are. Nevertheless, SEIU members have had to live with the fear and the stress of the star -- of the SARS epidemic.

Too many SEIU members were scared to death; they feared the unknown. For weeks, many were afraid to visit family. When they attempted to get information from their employers, they were told little.

A member at St. Michael's Hospital told us people in the bargaining of the epidemic were terrified. Hospitals may have been caught off guard and played down the consequences of SARS. From hospital, floor to floor, the responses to the crisis were different.

Our members lived with the fear and lived

98

through the quarantine periods, always putting the health and well being of patients they served first. They are also very understanding and supported their institutions efforts to combat the SARS epidemic.

I'm not as willing to accept the argument that SARS was a new experience for all healthcare providers, be they physicians, hospital management or healthcare workers.

At one hospital, ten (10) SEIU members were diagnosed with probable SARS. Countless others were in work quarantine or home quarantine. SEIU members are proud of the work they do. To work in -- in a healthcare setting with all of the stresses the system has been placed under, due to cutbacks and inadequate funding, healthcare workers truly do practice their vocations with love, kindness and dedication.

Under Ontario's Occupational Health and Safety Legislation, it is difficult for a healthcare worker to refuse dangerous work if the work refusal would directly endanger the life and health and safety of another person. No industrial worker would accept such a condition.

Healthcare workers put their lives on the line to help others. They deserve our respect and admiration. They, indeed, were the unsung, quiet heros of a tragedy. If it could not have been prevented, at the very least could have been better managed and controlled.

Our submission to you today is preliminary.

We have, and continue to gather, evidence as to what our members think went wrong. SEIU asks that you remain open to future meetings and discussions with SEIU Canada's leadership and our members in specific hospitals.

The Commission should hear from hospital support workers; their experiences can help to improve infection control techniques and occupational health and safety standards in all healthcare settings.

First and foremost, SEIU thinks the most important aspect of the Commission must re -- must review is infection control policies and procedures. If we had the proper infection control procedures and practices in place, SARS would have been arrested at the outset. In the early 1980's, hospital workers didn't wear their street clothes into the work place.

Hospitals have not taken a due diligence approach to infection control. Their infection control programs, we submit, do not meet the test of due diligence.

Our members have a right to be protected from injury and disease in the work place. Due diligence would require a hospital to foresee all possible transmissions of a communicable disease and take the precautions necessary to arrest its spread.

The SARS epidemic, from an infection control perspective, should be viewed as no different than an

outbreak of Tuberculosis or a flu epidemic. All have the potential to cause death. Many articles from peer review journals support our position on the need for more diligent infection control measures.

The state of infection surveillance and control in Canada acute hospitals states that:

> "Of the hundred and seventy-two (172) Canadian hospitals that responded to the survey, in 42.1 percent of the hospitals there was less than one (1) infection control practitioner for every two hundred and fifty (250) beds."

Just 6 percent of infection control programs had physicians or doctoral professionals with infection control training. The author states that there needs to be greater investment in resources to meet recommended standards and thereby reduce mobility, mortality, and expense associated with nosocomial infections and antibiotic resistant pathogens.

Other peer reviewed academic studies have also pointed out that hospital cleaning is a neglected component of infection control. Comprehensive cleaning disrupts the chain of infection between organisms and patients and suggests that restoring hygienic standards in hospitals would be a cost-effective method of controlling hospital acquired infection.

An evaluation of hospital cleaning regimes and standards claims that there is little doubt that environmental services can act as a source of pathogens which can give rise to infections. Roy Romanow's referenced several authorities to make the same point.

Canada lags behind many other countries such as the United Kingdom, the United States, and Australia, where national strategies are in place to improve quality and patient safety. The healthcare system itself is now being identified as a major cause of illness.

"Death and added costs because of errors and infections", says Roy Romanow, in his report "Building on values, the future of healthcare in Canada".

The hospitals claim that SARS presented a new and unique disease. While true, should not negate the responsibility to adhere to and to enforce the strictest infection control procedures. SARS was Toronto's hospitals' terrorist attack. They did not respond well to the initial onset of the disease.

Most hospitals never got out of the crisis -- never got out of the crisis management mode. A typical response was, this is all new and a learning experience for all of us. Hospitals support staff were the last to be informed and the last to be trained but the hospital housekeeping staff are key to controlling the spread of

infection. No one should devalue the work they do.

They can't be contracted out of existence. In fact, privatisation of more hospital services such as housekeeping and dietary services will fragment the integrated systems that are so vital to ensure the safety of all those who use hospital services and those working in hospitals.

SEIU recommends this Commission study the impact, the economics of contracting out and privatizing healthcare services have on the health of patients. International studies have shown that privatised health services have increased mortality and morbidity rates.

We need a Canadian study to examine the impact privatization has on hospital infection controls. Investigate the role hospital staff play in the containment of infection and disease.

From SEIU's perspective, hospitals, the Ontario Hospital Association, and the Ontario Ministry of Health, controlling the costs associated with SARS was more important than taking proactive measures to stem and eradicate the disease. The Ontario Health Authorities also minimized the impact of SARS.

On February 11th, 2003 the Chinese Ministry of Health notified the World Health Organization that three hundred and five (305) cases of Acute Respiratory Syndrome of

unknown etiology had occurred from November 16th, 2002 to February 9th, 2003.

On March 12th, WHO issued a global alert regarding SARS that appeared to place healthcare workers at high risk. On March 14th, Health Canada took steps to alert hospital workers, ambulance services and public health units. By March 19th, WHO had reports of two hundred and sixty-four (264) patients from eleven (11) countries with suspected and probable SARS. This number included three (3) deaths.

It is not until March 21st, that Ontario's Commissioner of Public Health urges all Ontarions, who are at risk of developing SARS, to call their family doctor, or call Tele-Health Ontario for more information.

In a press release of that date, the Commissioner is quoted as saying:

> "The risk of contracting SARS among the general population is extremely low. However, Ontarions who meet certain conditions should err on the side of caution and seek medical help."

By March 23rd, eleven (11) Canadians were reported as having contracted SARS. This number included three (3) deaths. On March 23rd, the Scarborough Hospital closes temporarily. March 24th, Ontario's Health Minister, Tony Clement, declares SARS a reportable, communicable and

virulent disease. This is almost two (2) weeks after WHO issued a global alert regarding SARS.
That appeared to put healthcare workers at a high risk.

For years, infection control in hospitals has taken a backseat because there have been no serious disease outbreak. It, therefore, was an easy item to cut from the hospital budget.

In one (1) hospital which operates three (3) sites, there is only one (1) full and one (1) part time infection control nurse.

Personnel assigned to SARS units, when no longer required -- were -- when no longer required on the SARS units, would be assigned elsewhere for the balance of the shift. The potential for the disease transmission increased because of this human resource decision.

MS. ROSS ANN CLARK: Good afternoon, Justice Campbell, my name is Ross Ann Clark. I'm a steward, a clerical steward representative at North York General Hospital and a Co-Chair for the Joint Occupational Health and Safety committee and when SARS originally surfaced, I was newly-appointed to the Joint Occupational Health and Safety committee.

Early on in the SARS phase, gowns, gloves and goggles, in some hospitals, were only worn in the emergency departments, SARS units and outpatient clinics. Others were

105

advised to wear only a surgical -- blue surgical mask at their own discretion.

When û95 masks were mandated, one hospital asked staff to wear only one (1) mask per shift. What happens if it gets soiled or wet?

A hospital president thanks everyone for their co-operation of having brought the number of masks down to fifteen hundred (1500) per day, from six thousand (6,000).

If cost containment is hospital management's concern, then it follows -- it can easily discount the value of unskilled workers such as housekeeping, transporters, team attendants and dietary services, all of whom have direct contact with the patients and visitors.

Keeping floors and surfaces clean is not a value-added component. They are essential components of keeping healthcare institutions disease-free.

Mask fit testing wasn't implemented in some hospitals; it is only on May 2nd, that the SARS provincial operations center issued a communication regarding mask fit testing, and it was nearly one (1) month after that, that fit testing started in one (1) particular hospital.

Two (2) months after the SARS epidemic first appeared, a hospital is still rationing masks. One (1) hospital in a communique to staff said:

"In order to ensure that we have enough

106

masks for staff and visitors in the hospital, we are asking staff to only leave with two (2) for each day until they return to work. For example, if you are working tomorrow, you wear one (1) mask on route home, and at home that day, and one (1) to wear the next day before changing into a new mask."

Since 1993, the Centers for Disease Control has issued performance criteria for masks to be worn when tuberculosis is suspected, along with fit testing guidelines. Why did Toronto hospitals, if their own infection control policies were inadequate, not adopt standard long established elsewhere?

In the absence of their own standards, they could have, at the very least, adopted inter -- international standards or benchmarked their practices against the international standards.

We go on to training and communication. Little or no training was given to SEIU members during the first phase of SARS. Training for PPE or personal protective equipment was not mandatory. If training was done, it was done only on departmental basis and rarely amounted to more than information sharing.

SEIU members ordered to SARS units were not

informed of potential hazards and were given no training. Hospital management and particularly, those in human resources positions require comprehensive understanding and training in health and safety.

With regards to Health and Safety Committee. The internal responsibility system trumpeted as the correct way to practice workplace health and safety since the Conservative government came to power in 1995 is an abject failure.

There is a culture in Ontario that has taken root since 1995 that says universal standards to protect public health are not necessary. We have seen the effects of this in our water supply and our meat inspection systems and just recently, the attempt to privatize our nuclear power plants. We can now add to that list the inadequate imposement of occupational health and safety standards.

This culture that local institutions and administrations can set their own standards must be pulled out by their roots. It is a poisonous weed that deserves immediate eradication.

Letters SEIU sent to hospital administrators and the Deputy Minister of Health for months remained unanswered. Joint occupational health and safety committees did not meet on any regular basis. In one instance, SEIU was told SARS is an infection control issue and not a healthcare

safety matter.

Ministry of Labour Inspectors no longer conduct workplace investigations unless there is a critical injury. Workers must be able to exercise their rights to know that their rights to participate and the right to refuse dangerous work.

Section 9 and 42 of the OHSA should not have been seen by hospital management as another attempt of workers to control workplace practices but rather as a tool to prevent disease and injury. The lack of consultation with GHSC, even during SARS II when finally the hospital got -- gets a wake up call, was sporadic and still some hospital administrators refused to hear from workers or their unions on health and safety concerns.

The Commission should investigate the impact part time work has on the hospital system. The working in one hospital rule limited many part time workers from making a living wage and limited our hospital staffing requirements. Hospital human resource policies such as bestowing rewards for good attendance in hospital settings have the potential to increase the risk of spreading disease. Some hospital staff take masking agents to cover up sniffles and headaches, when indeed these may be the precursors to more serious disease.

MS. SHARLEEN STEWART: In conclusion, in a

conference telephone call with representatives of the OHA, the MOHLTC and various unions, Mr. Hugh Macleod, Assistant Deputy Minister of Health volunteered that by not taking a systems approach to SARS, we put the system -- the healthcare system at risk.

Former Chief Medical Officer of Health for Ontario, Dr. Richard Schabas and various, charged on May 26th that hospitals let their guard down too soon because of political pressure.

Time and time again, the present Ontario government has failed to protect its citizens because of lax standards and practices. It's time we all took a more proactive approach to ensuring everyone's health and safety.

I would like to commend the government, however, for the compensation packages that they offered when the workers and our members were in a quarantine -- a work quarantine state and I certainly do encourage the government to continue that practice if we are unfortunate to be in this situation again.

We thank you, Your Honour, for the time you have given us today. We would like at a future date to present more detailed and concrete evidence directly from our members on the front lines. SEIU looks forward to working with you to see this to an end. Respectfully submitted.

MR. JUSTICE CAMPBELL: Thank you for your

submissions. Look forward to working with you as the Inquiry progresses. Thank you.

We'll take the adjournment now for the break until 2:15.

--- Upon recessing at 12:54 p.m.
--- Upon resuming at 2:14 p.m.

MR. JUSTICE CAMPBELL: The next presenters are the Ontario Public Service Employees Union.

MS. LEAH CASSELMAN: Thank you very much. Good afternoon. My name is Leah Casselman, and I'm president of the Ontario Public Service Employees Union. Thank you very much for this opportunity to speak here today.

I am here with Patty Rout, who is the Vice Chair of our twenty-eight thousand (28,000) member healthcare division council of OPSEU and Pat Collyer, who is the President of Local 575 representing two hundred and fifty (250) of our seven hundred (700) members of the Scarborough Hospital and Jack Arnott an OPSEU member and a respiratory therapist at the Scarborough Hospital.

Patty will speak about the impact of SARS on a wide range of healthcare professions and healthcare settings. Pat will talk about the impact of SARS on her members, at the Grace and General sites, and will tell how the union had to

step up and fill the void left by management in a time of crisis.

Jack will relate some personal experiences from the SARS crisis. Our union has asked -- was asked to participate because we do not ever want to have an experience similar to the SARS crisis that we have just emerged from.

SARS affected OPSEU members, not just in the Greater Toronto Area, but right across the province. Make no mistake, our members at the Grace and at the General sites of the Scarborough hospital simply went through hell.

First I'd like to say, on behalf of the members of our union, that these folks do what they -- do what they do not just in times of crisis. They do this work and face these hazards every day and they get very little recognition from society or from our governments for this everyday effort.

Clearly, during the healthcare crisis a hospital should be a haven of health not a vector of contagion. Healthcare workers should not be treated as pariahs in their own communities and, above all, hospital staff should not have to watch their co-workers get sick or die because they were not given the right equipment or instruction to do their work safely.

We, as a society, owe it to our healthcare workers on the front lines to give them every protection that

we can. For the government to run ads and call these workers heroes is a nice gesture but it fails to address the real issues, ongoing disrespect and lack of understanding and appreciation of the important work that they do.

For the government to make decisions like designating Scarborough Hospital as a SARS hospital without consulting the already exhausted and shell-shocked workers is an outrage. And who are these heroes, yes, doctors and nurses are important to the system, we all know that and respect the work that they do, but OPSEU members also provide important support and professional services inside hospitals and were virtually ignored in the directives, by the media and by the public.

To ignore the diversity of professional, clerical and service staff that make up the healthcare team, as was done during this crisis, is counter-productive and, frankly, dangerous to our healthcare system.

Our members will outline in this presentation why this is the case, but let me state another reality. There was no crisis plan in Ontario to deal with killer contagious diseases.

Given all the post-9/11 hype about bio-terrorism, it's hard to imagine our hospitals would have been so unprepared for SARS, but our members know that this is the case and it still is the case.

113

Furthermore, our public hospitals are under-funded and seriously under-resourced to do the job society expects them to do. Our members have known this for some time but the public and government obviously did not.

Let me draw attention to a survey of OPSEU hospital professionals done by Viewpoints Research. Among those findings, two-thirds (2/3) of OPSEU members believe the hospital does not employ enough staff in their job classification.

Six (6) out of ten (10) professionals regularly work sick to get the job done. More than three-quarters (3/4) of all professionals say staff shortages are negatively affecting patient care.

One (1) in four (4) staff have been made sick or suffered depression because of poor working conditions, one (1) in five (5) say that staff are making too many mistakes because of poor working conditions and staff shortages.

This survey was done in November of 2002 and was released to the public in January and is now on our website.

We did try to send out clear warnings. In February 2002, OPSEU members in hospitals across Ontario declared a day of action to protest and bring attention to staff shortages and horrific working conditions. Many risked

114

discipline to do this.

Our members were already stretched, themselves, to the limits of their resources under normal, pre-SARS conditions. We knew the system could not handle any kind of a crisis because it was already at the breaking point.

The severe shortages of key professions will continue to worsen as more and more staff near retirement or just simply burn out.

There is no surge capacity in the healthcare system. There is poor understanding of the precautions that need to be taken to control contagious and infectious diseases. There is no recognition when workloads are assigned that staff need time to put everyday precautions in place.

We, as a society, seem to have forgotten that really sick people, with highly contagious diseases can and often do end up in our hospitals. We simply don't have the right procedures in place to deal with these hazardous situations.

During SARS I and SARS II, joint health and safety committees did not meet. Protective equipment was not available. Contaminated protective clothing was not properly disposed of, and fit testing was either not done, or done improperly. Our members were again and again needlessly put

115

in harm's way.

It seems strange that we have procedures in place in our correctional system to deal with infectious diseases but not in our healthcare system. Our members' lives were at stake, and all we heard about was tourism and the economy.

We were disturbed and appalled that during the SARS crisis, so much focus was put on the economic impacts of SARS rather than on protecting the health and safety of our members. It was shocking to hear our members being told not to wear masks because, quote:

"It sends out the wrong message."

At a time when no one really knew how this disease was even being spread, nor how virulent it was; that's what happens when you take a business model approach to a healthcare crisis.

Hospital and healthcare administration is not just a business. Running hospitals with the same rules and standards as a manufacturing plant simply does not, and will not work.

You can't replace all managers who have a healthcare background with business school graduates. If people in positions of authority don't understand how the healthcare system works, and the jobs that people do at the most basic level, they will make the wrong decisions.

116

To compound this, hospitals are still run in a very paternalistic way, based on a nineteenth (19th) century model. Our healthcare professionals are knowledgeable workers in our healthcare system. They are capable of making sophisticated decisions if they are given the tools to so. If consulted, they can make a huge difference. Sadly, they are rarely consulted.

They are not consulted because they are not respected. Many of our members, like those of other unions, are also forced in two (2) or more facilities just to make ends meet and feed their families. Possibly the most shocking revelation of the whole SARS episode was that the Minister of Health was entirely unaware of the rampant use of a casual workforce, and how many staff are working at multiple sites.

Post-SARS, we still have workers that are regularly expected to work at multiple sites. Just-in-time inventory practices are translated into just-in-time workers. That's not the way to deliver high quality healthcare.

This is not just a quality of work issue though, but also, in the end, it's a public health issue. As well, the rationalization of services means sick patients are still being transferred around from one hospital to another.

It makes no sense for patients and workers to be transferred here and there and everywhere when the whole

idea of disease control is that of isolation and containment.
It is the ultimate irony that during the worst public health crisis in Toronto in recent decades the place that our citizens felt most unsafe was the one place that should have been -- they should have been able to go to to get better; the hospital. Indeed, the hospital was the vector of contagion for SARS.
Lastly, the Ministry of Labour also has a key role to play during this kind of crisis in ensuring worker health and safety is protected. The Minister should remember that if the healthcare worker is not protected, the patient certainly is not.
The Ministry failed utterly to understand and perform its proper role during this crisis.
Our members will now go into a more detail about how this dysfunction in our system is and how it can be improved. Patty...?
MS. PATTY ROUT: Thanks. Good afternoon. My name is Patty Rout. I am a Lab Technologist at Lakeridge Health Corporation in Oshawa. In addition to being Vice Chair of OPSEU's Healthcare Divisional Council, I am also Chair of our Hospital Professionals Division.
I would like to thank you for the opportunity to speak on behalf of the people I work with every day, as well as the many other dedicated healthcare workers that

OPSEU represents. Most are regulated health professional like myself. Many are in healthcare service in clerical careers.
They work in public hospitals, provincial psychiatric hospitals, provincial laboratories, ambulance services, public health units, community care access centres, community home care agencies, community mental health agencies, nursing homes and long-term care facilities.
We want you to understand the working conditions imposed upon us during the SARS crisis and the broad spectrum of workers that were forgotten by their management.
We want you to understand, as our employers do not, that there are more than just doctors and nurses who were affected and needed protection during the SARS epidemic.
To help you understand how these workers were all affected by SARS crisis, I will walk you through what happens to a patient, at various points, in the healthcare system, who they meet and what risks the worker is exposed to.
An ambulance paramedic may provide the first medical care to the SARS patient. In addition, patients were transferred from one site or -- of hospital to another site increasing the risk of infection.
Masks weren't issued for these workers

119

because initially they weren't instructed how to wear them and no one was fit tested.

The hospital admitting clerk is the next healthcare worker the patient or the -- and/or the family members interact with. A number of admitting clerks at the Grace were exposed to SARS and subsequently hospitalized and/or quarantined; yet admitting clerks were told that there was no need for a mask or any other protective equipment.

Every suspected SARS patient had to have a chest X-ray to help with the diagnosis. Some required other tests and scans, too. This brought them in close contact with Medical Radiation Technologists, who are required to move and position patients to ensure the proper views are taken for the necessary high quality results.

And depending on the time of day, these films may be taken in the Diagnostic Imaging Department or in the Emergency Department. This meant that patients were not put into the safer negative pressure rooms. In addition, SARS patients were wheeled through corridors on their way too and from the diagnostic department, possibly spreading their disease along the way.

An OPSEU member said; at the beginning of SARS Radiology staff were berated for wearing protective gear as it would frighten the patient. Then we were not in the first wave of mask fit -- fittings even though we were almost the

120

first group in the hospital to deal with the SARS patients.

Electrocardiogram Technicians were also frequently called to work with the SARS patients in emerge; yet they were not treated the same as nurses even though they worked in the same area.

Where the nurses did the cardiogram, they came gowned and masked and goggled times three (3) but the ECG technicians were told it wasn't necessary for them.

SARS patients, invariably, had respiratory complications, this brought them into contact with a respiratory therapist who would help to ventilate the patient, who is, unable, to breathe.

Aerosols or respiratory droplets were a real concern for these workers. Some doctors refused to wear striker suits, the higher level of protective gear that resembles a space suit. They also did not want the RSP to use them as it slowed them down. In some hospitals, the striker suits were in such poor working condition that the respiratory therapist was unable to use them. Jack will speak about these issues in greater detail.

Another important part of diagnostic testing is the blood work. A phlebotomist draws the blood from the patient and here is what one of our phlebotomists said:

"There was no training or instruction. Sometimes you wore double protection,

121

sometimes you wore triple and no one explained why. We deal with MRSA, TB, HIV. We know what to do with these diseases, why is it not the same with SARS? Nurses had people assisting them when they were in protective gear. We had our tubes of blood and no staff to hand them to. So many things went wrong. Our work load was incredible because of the sharing of casual staff and the shortage of workers. Many healthcare workers such as ECG techs, phlebotomists and x-ray technologists working on port -- portable machines are not stationed in a single location. Instead, they move throughout the hospital and have to worry about their equipment being contaminated, as well as themselves. During the SARS crisis they had to stop and clean equipment between patients. This took a lot of time.
In the hospital laboratories, lab assistants separated all the SARS specimens to prepare them to send to a provincial lab. They were told they need not mask, because there were no patients in the lab.

122

Well, maybe not, but, the samples came from SARS patients and these could have been highly infectious. Although universal precautions are used for handling specimens in a lab, no one knew, for a long time, whether or not, the virus was airborne, therefore these workers were at continual risk. Our infection control said; don't worry, you do everything under a hood anyway, but there were no fume hoods to work in. Members donned protective equipment even though their management told them not to, causing some unnecessary disagreements."
One submitted to the hospital:
"SARS patients come in contact with even more healthcare workers. The numbers vary according to the severity of the illness. At various times during their stay, patients come in contact with housekeeping staff, dietary staff, dieticians, physiotherapists, social workers, pharmacists and more. Nurses and doctors and emerge departments were told to double or triple their protection, but our members

who are working in the same areas are walking through those same areas without any protection at all. When nurses and doctors were quarantined because of possible exposure to SARS, it was not felt necessary for other staff, that had been in the same area, to be quarantined. Pharmacy technicians prepared the drugs for the SARS patients. They knew how to handle things in Pharmacy, but they did not know procedures for entering other hazardous areas. They entered infectious areas where probable SARS patients were being treated, such as intensive care and emergency, and no personal protective equipment was there. There was no signage to tell them what to do and no one thought they could be infected."

Communication was very poor. Healthcare workers watched to see what others were doing and then asked for the same equipment to be supplied to them. Often they were told that they didn't need it, but nobody explained why.

In the interest of time, it concentrated on acute care hospitals in the GTA, but a few words also need to be said about the other hospitals, as well as facilities

outside the GTA. Confusion reigned in rehab and long-term care facilities. In some areas there were no precautions in place to wait out the ten (10) day quarantine period. When there was a probable SARS patient they transferred him or her out.

Not all staff were contacted about the quarantine and many were afraid that they may have taken it home to their families. Communications to both patients and their families was very poor. At first, patients were not allowed to have their families in, so staff stayed extra hours to feed the patients.

Patients were extremely frightened and alone and therapists would spend time trying to keep the patients comfortable during the outbreak. Unfortunately, the SARS crisis was seen as primarily a GTA problem but because of the mobility of patients and staff there was a tremendous potential for it to have spread throughout the healthcare system across the Province.

We have OPSEU members in Sudbury who routinely come to Toronto to work weekend shifts in respiratory therapy. Patients who come to Toronto for specialized treatment are discharged home to distant communities. Families visited patients while SARS II was incubating unknown at North York General and then returned home to their communities.

125

All of these situations could have precipitated a far greater crisis. In community agencies, OPSEU members provide healthcare to people in their homes and schools. These dieticians, occupational therapists, social workers, personal home care workers, speech language pathologists, RN's and RPN's do not always know what they are encountering; this makes it difficult to put in place appropriate precautions to protect the worker.

This time, they found themselves in the front line of SARS with little information or protection. The SARS crisis placed a huge emotional physical toll on our GTA members.

I'm going to skip along because I won't have the time for everybody else. So I just would like to say that your recommendations should include all healthcare workers. We are the people working with these hazards. We should be part of the process in developing procedures. Pat...?

MS. PAT COLLYER: Good afternoon. I'm Pat Collyer. I'm a Medical Radiation Technologist that works at the Scarborough Hospital. I'm also the local president of OPSEU Local 575 that represents the professional workers at the hospital which includes respiratory, nuclear medicine, X-ray, ultrasound and many others as well as laboratory.

I'd like to focus my comments on where the --

126

what -- the issues that we -- we had to face as unions working within the system during SARS as union leaders. It was a very confusing time for everyone. We found that quarantines of members at the Scarborough Hospital at the Grace Division during SARS I; there were a great many inconsistencies as far -- from department to department.

There was no clear plan as to how we would quarantine members because we still have to remain servicing patients and maintaining, at least, essential services. So there was no essential service plan in place and I think, not to denigrate the Scarborough Hospital, I think this was clearly across the whole system.

There were never any plans in place to deal with, as Leah has said and Patty has said, a crisis of this enormity in the healthcare system. We dealt with issues from our members who then, when put on quarantine at home, I would receive e-mails from them at home saying, am I laid off? Am I going to be paid? Simple things like that that added to their frustration, added to their fears.

They were very fearful over the supply issues of masks and the lack of mask fit training. When we looked at issues such as striker suits, striker suits came to our hospital very late in the process during SARS II and then very few of them. So we were -- we were raising the issue of, well, you have them at one (1) site, when are we getting

127

them at the other site because we have SARS patients at both sites.

Then we got into redeployment of staff and there were great inconsistencies there. There was no master plan for how you would cope with redeployment of staff because of decreased workloads perhaps at the one (1) site which, when the Grace was closed, we definitely had in some instances lesser workloads in certain departments, especially the outpatient department.

We found that fan out procedures -- when SARS II hit, there was -- the fan out procedure was never utilized. We knew from SARS I that it had been -- because we had asked the question as union reps that it had been updated but it was never utilized; it didn't happen.

We asked for lists of our members who were hospitalized, this local had five (5) members hospitalized with SARS and we discovered when finally we got the list of the members that one of the members who we knew had been hospitalized with SARS was not on the list and we had to bring that to their attention.

So there was no tracking mechanism for -- within the system to track these folks, to track staff and what had happened to them and where were they, were they on home quarantine? Because of SARS, were they on -- because -- just because they had had contact and they were just at home.

128

These things weren't in place.

We had issues with right to refuse. We know that the government had gutted the Joint Health and Safety Act but we still had rights to protection under the Act and the first policies that came out of the hospital were flagrant -- had flagrant violations of the Act which we had to point out and we had to fight for our members for their right to be able to refuse to work if they weren't provided with the proper equipment.

We need, in the future, to look at the screening processes; that was a mess. The first day of screening -- I worked permanent night shift. I had staff coming in saying to me, we're standing in line and -- and we're side by side and we don't have a mask on and yet when we get into the building, we're not supposed to be in close proximity; what kind of -- what kind of a process is this?

And I'm sure again, that this was not unique to our facility because all of a sudden somewhere out there the POC or other bodies were saying, okay, now we're going to limit access to the hospitals.

Universal precautions was a cost-saving measure in my mind and I think that it failed the system badly and I think we need to really look at this. The fact that we were -- became social pariahs and the stress and strain that that created.

At one point we were told, well, you can't -- you can't use public transit, so you must cab it. We had one cab company in the east end that wouldn't take us. So those kinds of issues arose and it was a very difficult time for the staff.

They rose to the occasion, they challenged the system but they weren't always listened to and certainly it became the role of the union to challenge.

MR. JACK ARNOTT: Good afternoon, Commissioner. My name is Jack Arnott. I'm a respiratory therapist at the Scarborough Hospital Grace Division. I have about thirty (30) seconds so I'll be succinct.

MR. JUSTICE CAMPBELL: No, you've got a little longer than that, if you want. That's the five (5) minute sign.

MR. JACK ARNOTT: All right. My institution learned from SARS I. Unfortunately, the entire system -- healthcare system demonstrated that our learning wasn't translated to practice and that resulted in SARS II.

We have a lot more resources available to us now vis a vis ducts hanging by binder twine from the ceiling to make certain rooms now negative air pressure.

So we're getting there with our resources, we have a long way to go. My concern is two (2) fold.

One that healthcare professionals are going to

remain vigilant. I, myself, was quarantined twice. The first one was a working quarantine. My other concern is staffing levels. Throughout my bargaining unit which is lab respiratory and x-ray and I'm sure this is not -- I know this is not unique to the province; we're understaffed.

And with the possibility of a SARS III, I'm sure staff think that, oh great, something's here that I can take home and spread to my family.

It has happened with tragic consequences and unfortunately with the demographic bulge that is the baby boomers moving shortly into the position where they'll be significant consumers of our services.

We're understaffed as it is. To bolster the healthcare professional ranks is going to be next -- is going to be very difficult given the fact that there's going to be a demonstrated need for more of us and it's getting to be a bit scary. Thank you.

MS. LEAH CASSELMAN: Thank you very much, Patty, Pat, and Jack. OPSEU will be submitting a detailed written brief with specific recommendations following the Public Hearings but I would like to conclude today with some broad recommendations.

Governments and employers need a workable crisis plan in our healthcare facility for dealing with contagious diseases otherwise our members continue to be at

131

risk in the workplace. Hospitals are workplaces.
Governments and employers need to rethink the extent to which the business model has invaded our healthcare facilities. We need to ensure there is institutional memory of how to handle various crises and that those at the top can make decisions based on their knowledge of what is practical and effective.
Hospitals need to create more full-time permanent jobs for all healthcare workers, not just doctors and nurses. Governments and employers need to act quickly to stem the acute shortages of healthcare professionals by recruiting and working harder to retain professionals within our public system.
There needs to be better organization and communication in times of crisis. The union can help but our members should not be forced to do management jobs. Decision makers need to respect and understand the work of all members in the healthcare team, not just doctors and nurses, and we need to include all front line workers in the decision making process.
Governments and employers need to stop putting the economy and money before healthcare health and safety. If we don't take care of healthcare workers, health and safety on the job, patient care is compromised. If contagion is properly controlled, the economic issues simply go away.

132

One example of how the government has not learned from this today was a situation I was at this morning. We have eight (8) employees that work for the Ministry of Health and Long-Term Care at 185 Judson Road (phonetic) in Western Toronto.
These eight (8) workers are responsible for procuring all of the ambulances in this Province. They ensure they're built properly at the two (2) sites in this country, they ensure the equipment that goes into them is the proper equipment, whether it's the equipment that the paramedics use or whether it's test and respiratory equipment that are in those ambulances.
Their skills in procurement were used to get the û95 masks for all of the hospitals outside of Toronto during the SARS crisis. These folks do a fabulous job. They are getting their layoff notices on election day.
Every municipality will now be responsible for hiring and ensuring that they have the ability to go out and buy one offs on ambulances as opposed to the bulk purchasing that this group of workers is involved in. So this government has not learned any lessons from the SARS crisis that we faced.
Finally, the Ministry of Labour has to do its job and they need to get more actively involved in protecting the health and safety of healthcare workers without whom this

whole structure would collapse.
Once again, on behalf of OPSEU and the members that we represent, I certainly appreciate the opportunity to share this experience with you today and wish you the best in your work ahead of you. Thank you very much.
MR. JUSTICE CAMPBELL: Thank you for your presentation.
The next presenter is the Ontario Ministry of Health and Long-Term Care.

(BRIEF PAUSE)

MR. JUSTICE CAMPBELL: It's Mr. Hugh MacLeod, Assistant Deputy Minister, Acute Services Division.
MR. HUGH MACLEOD: Good afternoon and thank you for this opportunity to provide you with an overview of the SARS experience from the point of view of the Ministry of Health and Long-Term Care.
At the outset, I'd like to say that the Ontario government deeply regrets the loss of life and suffering caused by SARS and extends its deepest sympathies to the families of the patients who died.
As you know, the two (2) SARS outbreaks presented an immense challenge to all levels of the healthcare system. From the screeners at the hospital doors

to the paramedics and home care providers out in the community, to nurses and physicians and to other healthcare providers such as medical radiation technologists, cleaners, unit clerks and other care providers who came in contact with patients and contact with those who work in our enterprise.
People at all levels of the system were called upon to perform courageously. Over the past six (6) months and in discussion after discussion, a clear consensus has emerged. After SARS, our healthcare system has changed.
While we contained the spread of SARS, there is much we have learned and there are areas that we, as a system, need to work together to improve on.
Let me be clear, this was not a perfect process. In many ways, SARS unmasked some painful truths about our existing systems. Throughout the SARS crisis we had to face the realization that our healthcare system is a series of unconnected silos.
In this presentation, we will stress the need to work together to ensure the system is coordinated effectively for the future challenges that will present themselves.
Let me first give you a brief glimpse of our complex healthcare system. Ontario has one hundred and fifty-five (155) hospital corporations, has more than twenty-two thousand (22,000) doctors, more than one hundred and six

thousand (106,000) nurses, some twenty-three (23) regulated health professions, twelve hundred (1200) long-term care agencies, five hundred and fifty-seven (557) long-term care facilities, thirty-seven (37) public health units, forty-three (43) community care access centres and more than three hundred and fifty (350) community mental health programs and that's just the beginning of a long list of services that comprise our complex and expensive healthcare system.

As you know, the atypical pneumonia that eventually became known as Severe Acute Respiratory Syndrome, or SARS, first appeared as an unknown disease in Toronto in mid-March of this year.

Then on March 26th, 2003, in response to the outbreak of SARS in Toronto, the first provincial emergency in the province's history was declared. The numbers tell the tale of the unprecedented impact of the two (2) SARS outbreaks in this province.

Thousands of people were quarantined. There were two hundred and forty-seven (247) probable and one hundred and twenty-eight (128) suspect cases. We recognize the efforts of individuals, families and loved ones in the fight against this deadly disease.

From those whose families and lives were impacted by quarantine to those who battled on the front line every day and, finally, to those who gave the ultimate

sacrifice, the forty-four (44) who died, three (3) of whom were front line care providers.

At the core of every decision we made, every action we took was the overriding commitment to patient care, to the safety of the healthcare workers and the public as well as, of course, the containment of SARS. We developed and put into place new processes to enable tracking of this new and unknown disease.

As a system, we reacted collectively with the best information available, at that time. Together, we were learning and working to contain an emerging infection with no definition answers to testing, transmission, self-protection and treatment.

An underpinning of our decision and actions was to need -- was the need to weigh the needs of the community against the needs of the individual. For instance, we undertook the considerable impact of curtailing hospital operations but determined that it was better to do that than risk the spread of SARS to numerous other healthcare facilities.

That being said, we are profoundly proud of the work of the entire healthcare system in responding to the challenge of SARS, an initially unknown disease. SARS created a need for hospitals, for public health units, community care access centres and community services to work

137

as a whole and, in some cases, work very well.

As evidenced in the provincial transfer authorization system, a centralized patient transfer system from acute care to long-term care which worked extremely well.

Over the past months, we have been working closely with our healthcare partners across the province to examine the safeguards we need for the future.

The big challenge is quite simple; how do you stop an outbreak when you don't have a diagnostic test nor a vaccine and there is uncertainty around the incubation period with an unknown agent and a mode of transmission that is not entirely clear?

Let's take a look first at what worked and what we put into place. A twenty-four (24) seven (7) public health call centre to provide advice to hospitals and healthcare professionals and we rapidly deployed SARS screening including wearing of personal protective equipment, screening at hospital entrances and prone screening for outpatients and inpatient clinics and we developed mutual support amongst public health units to maximize deployment of human resources, but SARS not only shone a very bright light on many areas of our healthcare system showing us what worked but also provided us with some very hard lessons in real time.

138

From a communications perspective, SARS has taught us a lot. Not of least of which is that speaking with one voice through open, frank, honest, frequent and integrated communication is an essential as we move forward.

Being accessible is part of our responsibility as public servants and the public has a right to know how we are managing the system. Under supply of health human resources which is a global challenge became increasingly problematic and demonstrated the need for adequate supply of healthcare professionals but more importantly the need for a strategy to deploy them in a crisis and when we have a surge response required. The lack of a domestic mask supplier and an insufficient inventory of masks to deal with the infection protocols as the emergency progressed was also problematic.

Never has it been more obvious that information and its rapid analysis and sharing is the bedrock of effective emergency planning. The future ability to instantaneously transmit information is paramount and we all need to be more effectively using the information technologies that are available to us.

The reality of disease transmission between the previously described components of the healthcare system mean that we need to work together to build on the shared approach and collective intelligence we fostered out of necessity during SARS.

At the heart of this call for enhanced system integrations will undoubtedly will be phrases like better coordination and better system synergy. SARS has also underlined very clearly the need to strengthen how we undertaken contingency planning. This is true for every level from the ministry to the front line of our delivery system.

The key question we now face is how the healthcare system should be changed to better prepare us for the future. Our key asset, our core capability is know how, which resides in people, people like the presenters here, families and those who are working on other Commissions like this one.

The work of this Commission will be an important part of our go forward plan. In addition, the expert panel chaired by Dr. David Walker will examine the lessons learned during SARS and respond and provide advice to the government regarding measures to strengthen infectious disease control and service delivery during an outbreak.

SARS in Ontario was principally a hospital acquired infection. As a result the importance of effective infection control measures in every institution must be reinforced and we all recognize the need to adopt a more robust precautionary measurement system.

Over the past several months the Ministry has

issued directives to the field that masked the level of protection required for staff and patients to the risk of SARS in the community. These directives have been based on the best scientific evidence available at this time and more importantly draw upon the expertise of leading clinicians.

The new normal directions issued by the Ministry of Health and Long Term Care reflect our heightened awareness of the emerging infectious diseases such as SARS and include direction on the prevention of exposure, early detection of new cases and protection of others in healthcare facilities and in the community.

In the coming weeks, we will be sending out additional materials that update current practices in the pre-hospital acute care, non-acute care and community settings and provide information on both outbreak and non-outbreak conditions, and we'll be working with key stakeholders to ensure proper implementation.

This material has been and is being reviewed by reference groups prior to distribution to ensure the ease of use. The reference groups include the medical reference group, the Ontario Hospital Association, public health, the SARS Nursing Advisory Committee, the Toronto Reference Group and Health Canada.

These reference groups reflect the diversity of health service providers. The feedback to date from the

reference groups has been helpful as it reflects the high level of commitment to sustained vigilance regarding SARS and also the diversity of opinion as to how that is best done.

The most important result of SARS that we want to stress is that the lessons need to be acknowledged and acted upon by all of us, by government, by healthcare facilities, by healthcare providers and by the public.

If we are to stem the unprecedented challenges to our health system, illness and death, the enormous pressure on front line care providers and the billions of dollars in both health costs and negative economic impact, then we must change our attitude and we must change our behaviour.

How our system was able to weather the global storm of SARS and retain effective working relationships in a time of immense personal, social and psychological stress depended much on genuine heroism, courage, and devotion at the front line and also depended on genuine stewardship and leadership during a period where we had more questions than answers on how to handle this new and complex disease.

We succeeded, albeit with a human cost, because we were able to combine our collective intelligence to deal with day-to-day challenges. Many people and several organizations achieved remarkable results through actions that were executed within accelerated time frames.

We also must acknowledge that globalization, world travel, all conspire to guarantee that SARS is the latest in a series of diseases that include Influenza, HIV and AIDS, Mad Cow and West Nile Virus. Therefore, we must continually ask the important question; how should the healthcare system be changed to better equip us for the future challenges?

From SARS, we still have questions that need to be answered but we have new and improved processes and, more importantly, we have hope for the future. We have emerged with an increased awareness of the value of a concerted and committed human effort to ensure the safety and well being of healthcare providers and the public, both in Ontario and beyond our borders.

Thank you to the countless individuals at all levels of the system who were called upon to perform and did perform with devotion and courage in an exhausting and fearful environment. For all of the immense fear and anxiety associated with fighting this unknown disease and the anger that arose, we must recognize that people lost their lives and Ontario went through a great upheaval.

Their fight will not, cannot, go unrecognized and must be part of helping build a new framework for future challenges.

Thank you for the opportunity to speak before

this Commission and we look forward to receiving your recommendations.

MR. JUSTICE CAMPBELL: Thank you. We'll take a ten (10) minute break before the next presenters.

--- Upon recessing at 3:04 p.m.
--- Upon resuming at 3:12 p.m.

MR. JUSTICE CAMPBELL: The next presenter is North York General Hospital.

MS. BONNIE ADAMSON: Mr. Justice Campbell, members of the SARS Commission, esteemed colleagues, ladies and gentlemen, my name is Bonnie Adamson, President and CEO of North York General Hospital and with me is Mr. Ken Morrison, Chair of the Board of the Hospital of North York General.

Thank you for the opportunity to participate in this Public Inquiry. We appreciate the chance to share with you some experiences and insight the hospital gained during this unprecedented challenge of dealing with the SARS outbreak.

At the onset, let me state unequivocally how proud we are of everyone at North York General Hospital for the way they rose to the challenge. As a Registered Nurse, I know very well the pressures faced by front-line healthcare

providers. SARS was a completely new experience, adding new layers of pressure both professional and personal.

It is a credit to our staff, our healthcare professionals, support staff and management that they persevered and succeeded in containing the spread of SARS which could have been much worse and, as importantly, we succeeded in always providing a high level of care to our patients.

One of the purposes of my presentation today is to convey to you a sense of how SARS impacted North York General Hospital. This Commission has been established to better understand what happened with SARS and to develop recommendations for systemwide improvement so it may never happen again.

We applaud this process and am pleased to provide our input. We gained a great deal of knowledge during SARS and we believe this knowledge will assist us as we all work together toward system-wide improvements.

Before sharing some of our recommendations, I want to focus on the human story of SARS at North York General Hospital - a story of compassion, dedication and heroism. I think it's fair to say that 2003 will go down as an important year in the history of North York General Hospital.

For one thing, we celebrated our thirty-fifth

(35) anniversary this year. In a couple of weeks we will be officially opening our brand new state-of-the-art southeast tower launching a new era of high quality healthcare for our community but in those -- between those two (2) milestones we had SARS.

North York General Hospital has been described as the epicentre of SARS II. In truth, for North York General Hospital there was no SARS I or SARS II. We never really got out of SARS I, so, there was no break. For us, SARS lasted almost five (5) months.

We went from thirty (30) SARS patients in the first wave to more than ninety (90) during the second wave, half of them our own staff and some of them are still recovering. Even as the first SARS crisis appeared to be over, we continued our vigilance.

The reason we were so cautious is that we still had SARS patients in our hospital. We could not and did not return to business as usual.

I want to emphasize here that we did not let down our guard. Some individuals and certain journalists have repeatedly put forward the notion that concerns about a return of SARS at North York General Hospital were discounted or ignored. This is simply not true.

In fact, the idea that anyone, let along medical professionals, would wilfully ignore SARS just

doesn't make any sense. The concerns were heeded. We were aware of the cases and the symptoms and we treated them based on the guidelines at the time. Obviously, we know more now about how SARS spreads, although there are still many questions about the disease and hospitals have provided -- developed new protocols.

Based on what hospitals knew at the time, we consulted with experts and took the appropriate precautions. As we gained more knowledge about SARS, we continually updated those protocols, a process continuing through this Commission.

SARS II, when it did hit brought with it unprecedented challenges. A disease we knew little about suddenly re-emerging within our own walls. An anxious staff fearful not just for their own safety and wellbeing but even more worried about taking the disease home to their loved ones.

An exhaustive staff as the crisis stretched from weeks to -- days to weeks to months with little relief. Extraordinary safety precautions requiring staff to wear protective gear that made them look and feel more like riot police than healthcare workers. The gut-wrenching reality of providing care to our own staff stricken by SARS and the challenge that hit the hardest, the death of one of our colleagues, nurse Nelea Laroza.

147

Police and firefighters have an innate understanding of the dangers of their jobs but I don't think most healthcare workers thought about dying in the line of duty. It was a tragedy, but at the same time it brought home how healthcare workers really are heros.

On behalf of North York General Hospital, we want to express our heartfelt condolences to the families who lost loved ones to SARS. We at North York General Hospital fall into that category because Nelea was a member of our family. As a hospital, helping people deal with grief is one of the things we do every day but I can tell you, losing one of our own, it is very hard.

It is a credit to our staff that everyone pulled together showing the same compassion and dedication to helping each other as they so often show for our patients.

Also I want to take a moment to pay tribute to SARS patients, including our own staff, who are now thankfully recovering. Their fighting spirit, their refusal to lose hope is what kept the rest of us going through the darkest days of the crisis. SARS was, to say the least, a very emotional time. Ultimately, though, we prevailed and the stories that have emerged paint a picture of compassion, dedication and heroism.

Let me share with you a few illustrations. Despite their own fears, staff from all over the hospital

148

volunteered to work in the SARS units. Their show of compassion was truly inspiring, as they set aside their own concerns to do what they could for our patients. Often that meant spending time just chatting with patients or holding their gloved hands to try to each their sense of isolation, even when patients were unable to physically respond.

The SARS unit was described by a number of our staff resembling a M.A.S.H. unit, a group of people thrown together in difficult circumstances trying to make the best of it. As such, it was surprisingly upbeat even among patients. They obviously couldn't interact with each other but they could talk to one another on the phone and ended up making -- forming support groups that way.

To help SARS patients pass the time in isolation, one of our child and youth workers applied his recreational skills providing videos, magazines and other distractions. We brought in clock radios for each patient, so they could at least know what time of day it was. For some patients who could barely move, our staff would spend time tuning the dial and the patient would nod or blink when they found a song they liked but loneliness was not solely the domain of patients.

In the effort to contain the spread of SARS approx -- at North York General Hospital, approximately seven thousand (7,000) people were put in quarantine which we

149

recognize was a tremendous hardship for them and their families; that includes more than four thousand (4,000) of our own team who had to endure a home/work quarantine. For many of them the situation made them feel like pariahs in their own community. We heard reports of neighbours crossing the street to avoid houses where our staff lived and even an eviction notice to one of our staff members by nervous roommates.

But, again, our human spirit came to the fore. The human resources department and the hospital foundation set up a compassionate care fund with donations from physicians, staff and outside reporters and through that fund we were able to help those affected by SARS cope with the financial and personal hardship brought on by the predicament.

SARS was a time of great personal sacrifice for our staff and their families. Many were unable to attend important family milestones: weddings, graduations and even the funeral of parents and these are events that could never, ever come back.

We had reports of our staff sending their children to live with relatives so they wouldn't have to deal with the quarantine restrictions. Yet despite what, in many cases, were crushing personal disappointments, our staff never wavered from their dedication to patient care.

150

Within the hospital itself, nothing was routine about SARS. As one example, SARS patients needed chest X-rays at least once a day. Obviously they couldn't go to the diagnostic imaging department so the technologists brought the portable equipment up to the SARS units. That meant putting on ful protective gear, pushing the equipment to the unit, taking the X-rays, while working around IV's, tubes and wires and then scrubbing down the machine to prevent possible contamination.

All tolled, each of these simple procedures took a half an hour and there was a steady parade of technologists and equipment up and down our halls constantly. One of the most memorable stories involves a SARS patient who spent eighty (80) days on life support.

After she contracted SARS, she lost her job and was abandoned by her family. Even though she was too sedated to respond, our staff continued to comfort her so she would know that people were caring for her. And when she was finally able to speak her first words were to thank those who stood by her and I quote

> "These people are like my angels. God bless them".

Today, she's recuperating supported financially and emotionally by some of our physicians and our staff as she rebuilds her life in our community. These are

151

just a few examples of the human side of SARS and the heroic way North York General Hospital team answered the call.

At the same time, there was also the business side of the hospital and as SARS progressed, we faced numerous operational challenges. Just to give a few examples, knowledge about SARS changed from day to day and sometimes hour to hour resulting in frequent changes to rules and regulations.

We were on the receiving end of communications and directives from multiple sources. We steadfastly followed the directives at all times but it wasn't easy in an ever-changing environment.

At all stages of the SARS outbreak, we were faced with new situations. Based on the knowledge we had at the time, we are confident we made the right decisions. We listened, we consulted, we confirmed our course of action with experts inside and outside the hospital. We followed directives carefully and we took all of the appropriate precautions.

As the scope of SARS outbreak grew, we needed to increase our SARS capacity in a hurry. Virtually overnight we were able to create an enormous intensive care unit, first by overhauling our existing unit and then by fast-tracking the ICU in our new building. North York General Hospital was able to open more than seventy (70)

152

rooms with the mandated negative pressure and, as we understand it, that's more than any other hospital in Toronto.

Mask fit testing for our staff quickly became a major issue. We had to fit four thousand (4,000) staff. A time-consuming process and we certainly didn't have a lot of time to spare. Partway through the crisis came the forming of the alliance for four (4) healthcare facilities to deal with SARS. We welcomed the opportunity to be at the forefront of infectious disease control.

Communication was constant both within our organization and with outside partners. Teleconferences became a major part of our daily routine. The exchange of information was crucial and teleconferences were a mechanism to try and keep everyone up-to-date.

On one (1) day alone our staff participated in fourteen (14) conference calls with their colleagues throughout the system. The hospital switchboard was close to overheating. Individual departments were also inundated with calls as staff, patients and families frantically looked for answers that in many cases were not available.

SARS was, of course, big news and handling the media became a constant challenge. In some ways we appreciated the opportunity to communicate with the broader public but other times, it just added extra pressure. I wish

153

I had a dollar for every television crew that asked to film inside the hospital which was, of course, off limits for just about everyone.

It became apparent early on that we needed to establish staff support strategies. How, for example, does a single mother of three (3) buy diapers and take her children to daycare when she's on work/home quarantine? Thankfully, volunteers came to the forefront and we helped make other logistical arrangements so our staff could take care of personal business.

We also recognized the need to provide emotional and physical well-being support and put a variety of counseling programs in place to help our employees cope with unprecedented and very difficult personal circumstances. It's worth noting that many of these measures are still ongoing. We recognize that our staff have gone through an extremely stressful episode and one of our priorities now and in the future is to ensure that the necessary support systems are in place.

Education was another key priority and still is. Both during and subsent to -- subsequent to SARS, we've been implementing comprehensive programs to train and educate our staff on infection control. Many of the protocols established during SARS, such as a renewed emphasis on hand washing remain in place.

154

As the SARS outbreak took on greater dominance, we knew we had to start shutting everything down - among the first to go was obstetrics. The birthing centre in our new tower had just opened and was a point of great pride for all us, so it was particularly painful watching it close its doors; not to mention the challenge for our healthcare team and our patients in finding different facilities for all those mothers-to-be, but, we were committed to not abandoning our patients and similar scenes took place in every department. Our cancer clinic, for instance, worked long hours to find doctors and reschedule chemotherapy. We established an off-site chemotherapy facility as soon as we were out of quarantine and even during quarantine, a telephone support network was established.

I think if one tribulation stands out from SARS, it was the necessity of treating our own staff. The number of staff patients we had skyrocketed. At one point, we had forty-seven (47) SARS patients and half of them were our own staff, including a number of physicians; that is perhaps the most memorable and haunting aspect of SARS, the surreal atmosphere.

Here we had healthcare workers treating their colleagues who had become ill and critically ill by treating others in exactly the same environment. We had battled-hardened physicians and nurses in tears, faced with a

---

situation for which no amount of training and experience could have prepared them.

These are just some of the -- some of the on-the-ground challenges we faced during SARS. We succeeded in dealing with them and we learned a lot along the way. Because SARS was such an unprecedented situation, our response developed along with our knowledge of the disease. We were constantly adapting, changing our protocols as new information became available and as we received updated directives. It was an evolutionary process and we continue to evolve.

Let me share with you some of our recommendations to improve the entire system so we are all better prepared to handle future crises.

Number 1, we need more investment in emergency preparedness. I think SARS made it abundantly clear we need more resources, both in terms of expertise and physical plant, to identify combat and control, the spread of infectious disease and to be ready to deal with large emergencies as they arrive.

Number 2, the new normal needs to be permanent. Hospitals are first and foremost healthcare facilities and we have to have precautions in place to ensure the safety of our patients and employees and if that means tighter restrictions on visitors and commercial enterprises,

then so be it.

Number 3, people cannot and should not work when they are sick. We need to ensure that systems are in place to provide the necessary support and flexibility.

Number 4, we need to develop more active communication systems within our institutions to build trust, address conflict and be more responsive to staff. Again, the suggestion from some quarters that we ignored or discounted staff concerns is simply not accurate. No reasonable person would disregard such concerns and we did take them seriously. Nonetheless, we recognize we can always improve by carefully listening to our staff and letting them know we have heard them.

Number 5, we also need to be better at talking to each other within the healthcare system, both inter-hospital and inter-agency. SARS has served as a reminder of how closely linked we are. As part of our expanded surveillance, we need to share information and collectively monitor across the system. We need an integrated monitoring program to track patients as they move between institutions.

Number 6, we need to pool our leadership to bring together our collective knowledge and lessons we have learned as we move forward together.

Number 7, collectively we must address a critical shortage of nurses and other health professionals

and medical specialists. A comprehensive human resource strategy is needed to address both short and long-term requirements as well as the quality of work/life balance within our profession.

And, finally, number 8, we must continue to be vigilant. Ontario lost forty-four (44) members of society to SARS, three (3) of them healthcare workers. I think that perhaps the most appropriate tribute we can pay is to always recognize the risk and take the necessary steps to keep everyone safe and part of that means monitoring our working conditions at all times.

Many of the lessons learned from SARS are being implemented right now and we are better prepared to deal with SARS if it should happen again; better positioned to handle new infections or new permutations of existing diseases. We have already made significant changes based on the knowledge gained from SARS.

A sophisticated patient screening and triage system in our Emergency Department is one (1) example of how we are moving forward from SARS ensuring that we continue to provide a high level of protection for patients, staff, volunteers and visitors entering our hospital. We've increased the number of isolation rooms with improved ventilation.

We have tripled the size of our infection

control team and continue to recruit. We've expanded educational programs in infection control for our staff including instructions on CD-ROM. We now have the capacity to establish an assessment clinic quickly.

Our occupational health policy is now more stringent. We are actively improving communication with our staff, increasing management visibility and accessibility and implementing a new participative committee structure.

We will continue to strive to better understand our staff communication needs and how best to meet their needs and expectations. These are just a few illustrations of how our experiences with SARS have helped us develop and implement new procedures and protocols.

We look forward to building on what we have learned both in the personal experience and with information shared through this Commission and other studies.

In conclusion, let me say, once again, how proud we are of the way North York General Hospital staff handled this crisis. We also want to reiterate our commitment to building on the knowledge and expertise gained from this highly emotional and stressful experience.

Mr. Justice Campbell, in the course of your deliberations you'll hear from a wide range of healthcare professionals. We are confident you will pick the best ideas to create the best solutions for our healthcare system in the

159

future.
North York General Hospital pledges its full support as we too move forward to address the healthcare challenges for generations to come. Thank you.
MR. JUSTICE CAMPBELL: Thank you for your presentation.
The next presenter is the Scarborough Hospital.
MS. GLENNA RAYMOND: Good afternoon. I'm Glenna Raymond, CEO at the Scarborough Hospital. I wish to thank the Commission for providing the Scarborough Hospital with the opportunity to address this public meeting today.
I would also like to acknowledge the presence, with me, of many of the Scarborough Board of Directors and colleagues who are here in the audience today. They are just a sample of the men and women who come to work at the Scarborough Hospital every day and are true heroes.
I understand the Commission's mandate to be to determine the facts about the SARS epidemic so that we can learn from our experiences and strengthen our healthcare system. We all want to do everything we can to ensure Ontarians receive the very best and safest care possible.
While we must acknowledge that it would be impossible to cover everything that was involved in such an incredibly complex situation in my thirty (30) minutes today,

160

I want to restate our hospital's commitment to this Inquiry and we welcome any opportunity to provide further detail to the Commission subsequent to my presentation today.
This has been an unprecedented year for the Scarborough Hospital and for healthcare institutions around the world. This was truly an international health crisis, one that began far from the Scarborough Hospital but wound up having such a deep impact on our community.
As the first hospital in Ontario to encounter this internationally unknown illness, our eyes have been opened to both the vulnerability and the strength of our system. During this outbreak at the Scarborough Hospital, more than one hundred (100) of our staff became ill with SARS.
We assessed over three hundred (300) patients in our SARS clinic and we treated a very significant percentage of Ontario's SARS patients. Faced with this, indeed the most tremendous challenge in the history of our hospital, the Scarborough Hospital staff and physicians quickly stepped up. They selflessly put the health and wellness needs of our patients and community first, taking personal risks and making great sacrifices.
Last Spring, we experienced the isolation and the stigma associated with being the so-called epicentre of the outbreak when all of this was too new for others to

161

understand. While this was terribly painful for our staff, our physicians and our community, we quickly appreciated the scope and significance of what we were confronting and we faced it head on.

In those early days, we could not have predicted the impact to come. Let there be now doubt, we will never forget those families, friends and staff so deeply impacted. However, a part of what helps us move forward is the recognition of the sheer dedication of healthcare workers.

Indeed, had our own healthcare workers not acted so quickly with such courage, compassion and tireless commitment this situation would have been even more tragic. I want to describe for you the initial response by our clinical and infection control team; the extraordinary team that mobilized throughout the hospital and sustained that effort until the situation stabilized.

Throughout, we grounded our decisions, first and foremost, on the health and safety of both patients and caregivers and we instilled an approach to learning and scientific inquiry. Early on we engaged the expertise of external infectious disease specialists, working closely together to put the pieces of this mysterious puzzle together. In retrospect, these factors contributed significantly to the containment of this unknown illness and

162

to the system's learning going forward.

The first person in Ontario to contract SARS was an elderly woman who died at home on March 5th. Her son came to the emergency at our hospital on March 7th with respiratory symptoms. Our initial diagnosis was Atypical Pneumonia. This patient was treated according to the Canadian guidelines for community acquired Pneumonia; this includes antibiotics, fluids and did not stipulate isolation precautions.

At that time, there was no information about SARS, the specific virus had not been identified and there was no test for a SARS diagnosis. This was five (5) days before the World Health Organization issued an alert about this completely unknown illness.

On March the 8th, this patient was admitted to a medical unit. The same day he was admitted to our Intensive Care Unit as his respiratory symptoms became more severe and only three (3) hours later isolation protocols were started with the query of Tuberculosis.

This introduced early isolation precautions and was a significant initial step that helped prevent transmission further.

The Scarborough Hospital is an urban community hospital with -- very much in tune with the characteristics of our particular patient population and catchment area. As

163

a result, our doctors have a heightened awareness of Tuberculosis.

While pneumonia had clearly been diagnosed, and although the rapid progression of symptoms in this patient was not characteristic of tuberculosis, the clinical team was thorough and holistic in their approach to care.

In particular, they showed great compassion for a family who had just experienced the death of a family member. Some of the patient's other family members had coughs and x-rays were ordered. On Sunday, March the 9th we notified Toronto Public Health.

Our ICU patient care manager and nurse educator also played a very significant role in the initial clinical team response. Well-connected with our community, this nurse regularly reads the Chinese community newspapers and was struck by a particularly tragic story about the mysterious death of a father and daughter in Asia.

The causes weren't clear but it was reported the family had just returned to Hong Kong from a trip to mainland China. With extraordinary assessment skills, our ICU nurse considered the travel and family history of our patient and alerted the attending physician. They had further discussion with Public Health and internal and external infection control specialists.

Tests for tuberculosis and for an avian flu

164

virus were both negative and the clinical team continued to search to learn what this new illness was. Stepping up to a very real problem to identify real solutions, they continued the early isolation precautions for this patient with an unknown respiratory illness.

After caring for the first SARS patient, long before the nature of the disease were known, one of our critical care nurses contracted the virus, and within a very short time, she became so weak she could not walk across the hallway. She experienced fever, aching and laboured breathing. Thankfully, she has returned to good health and is back at work in the ICU.

She speaks about her experience with SARS and her exposure to such great risk with the humility so typical of our healthcare workers. She says that she never felt her life was in danger,

"I got sick; now I'm better. That's it." she says.

There are countless stories of this tremendous courage, confidence and leadership from the Scarborough team that dealt with this new disease that we now know as SARS, before the diagnostic tools, identification of the virus or understanding about the transmission was known.

In studying the past months of activities, we acknowledge that, for our health system to be a strong one,

we must continue to find ways to accelerate our learnings and process new information from around the globe quickly. As an urban community hospital with deep community connections, we are committed to contribute to this; however, the broader system can ensure mechanisms for faster flow of information, scientific study and dissemination to all providers.

Our infectious diseases outbreak team was quickly mobilized on March the 13th. We began detailed tracking to identify patients and staff who had had contact with our first patient.

The hospital's infection control contact tracing involves looking back to identify who the infected person has been in close contact with and then notifying Public Health of these contacts.

This involves an extensive review of patient registration lists, staff schedules and detailed chart reviews of all contacts.

The outbreak team focused on the initial patient and identified contacts from his arrival in emergency on March the 7th, until the time the isolation procedures had been initiated in the ICU, on March the 8th.

Hospital staff followed up with those individuals who were still in-patients with us, initiated isolation precautions for them and referred the others to public health, who has the authority for community follow-up.

Without the knowledge we have now about the spread of the virus and the ten (10) day incubation period, there was no way of knowing that the illness had unfortunately already been passed to others in the community, in the Emergency Department at our Grace site and to our staff.

As other patients and staff began to experience symptoms, we sought additional help to discover the pattern of transmission. A collaborative team of hospital staff, infectious disease specialists, public health authorities and occupational health staff worked around the clock to do comprehensive contact tracing.

What was emerging between March 14th and March 22nd was a very complex transmission and a pattern that can be recognized only historically. With an exponential spread of infection, the numbers of potential contacts were far greater and the task more complex than had ever been encountered previously.

While the method was sound, the system's human resources and information systems were not sufficient to update or refine previously produced tracking lists in real time as patients continued, were discharged and readmitted or as patients moved from one hospital to another as was the case with one (1) of our patients who likely contracted the virus on March 7th or 8th, having visited our emergency

167

twice, was discharged and several days later was readmitted and then transferred to York Central Hospital, his home community hospital.

Looking forward to realistically accomplish such an enormous tracking task our broader health system will require information systems with continuity of patient files and flags as information is shared among providers and among community and hospital components.

In addition, we will need a team of analysts at the ready to provide the human resources for this magnitude of contact tracing.

With tremendous collaboration our dedicated team worked twenty-four/seven (24/7) and through their study of the contacts they generated new knowledge about the spread of illness and the protection needed, including the introduction of û95 masks and goggles and special personal protective gear for use during certain procedures and we learned more about the quarantine time period that was required.

Through all of this our nurses, doctors, family physicians, infectious disease specialists and other staff worked with external experts and all internal staff to care for patients, support each other and put their healthcare profession ahead of themselves and their own families.

168

We are so very proud of this extraordinary group of people and continue to be inspired by them.

It is also important to note that early on, while the illness was still unknown, we also initiated a proactive response at our general site which included emergency department assessments using a procedure that later became a provincial directive regarding screening.

In spite of round-the-clock efforts to uncover the transmission path as we became aware of this new illness, and despite a head start because of the excellent assessment and actions of our critical care team, the complexity of this unknown was outside the normal realm of our or any Ontario hospital experience to date.

An internal crisis response plan was initiated. Public health and Scarborough Hospital command centres were established on-site. Communications were provided to staff, patients, visitors, volunteers and our community twenty-four (24) hours, seven (7) days a week, electronically, through special hotlines we established, through our website and newspaper ads.

Many of these resources that we produced internally were not yet available from external resources but became guiding documents for the broader system as time went on.

Hourly internal management and staff meetings,

169

conference calls with external specialists, three (3) government levels and other healthcare partners ensured constant information exchange and updates.

Isolation precautions were instituted throughout the hospital with education teams deployed to instruct staff. These measures would later become provincial directives. Visiting and patient services were restricted. Our occupational health nurses assessed staff around the clock.

All of this was put in place within two (2) weeks of the first patient, a time when this new virus was yet to be identified. We held daily staff meetings to communicate about the situation and I recall one question asked: why the results of tests could not be obtained more quickly? Our answer was straightforward. At that time, there was no test to confirm the virus; it was not available.

I have said that our hospital was the first in Ontario to respond to SARS. As a result, the international healthcare audience continues to seek us out to share our experiences.

Our people have made a lasting contribution to how infectious diseases are treated but during the period of containment, unable to move patients out and everyday finding fewer colleagues to give care, in quarantine and anxious for their own family and friends, what is truly remarkable is the

170

sustained dedication and teamwork that enabled the Scarborough Hospital to provide care for our patients and to provide leadership within the healthcare community; this was our most important lesson about what makes our hospital such a strong healthcare organization.

I also want to again acknowledge the overwhelming show of support from the many community groups and business partners. We are fortunate to have such a caring community and it is the spirit of cooperation that brings people together, nurtures our healthcare workers and has had a positive impact on our community.

The health and safety of our patients, staff and physicians was always our number 1 priority and we have found many specific lessons about improving infection control screening and surveillance. We have led in research to generate much new knowledge about care protocols and effective treatment.

Indeed, we played a key role in the very first scientific study relating to SARS, it's epidemiology and treatment. That study was published in the New England Journal of Medicine in March 2003, the same month the unknown illness appeared in North America. We have developed education materials and procedures for use of personal protective equipment.

Our local environment is safer, not only for

171

patients but for staff, physicians and volunteers. In particular, we have significantly increased our isolation capacity and the number of our infection control specialists. We continue to employ self-screening and we have incorporated patient screening with triage as new patients present to our hospital.

It's useful for me to take a few moments to also provide the Commission with some lessons we learned about the broader healthcare system through our SARS experience.

First, we learned how necessary it is to improve the flexibility of our healthcare system to have capacity for emergencies. As we strive to maximize the efficiency of our healthcare investments, we typically operate our hospitals at capacities near 95 percent.

When SARS hit the Scarborough Hospital, we had to quickly learn and implement ways to increase flexibility of our organization. Not only did we have to free up beds and build SARS units, but we also had to use our human resources in the most efficient manner.

We prioritized only the most urgent of surgical cases, identifying those that could be safely postponed without risk. We discharged patients working closely with our colleagues in other sectors to mobilize community care resources.

172

Within our multi-site facility, we combined pediatric, obstetrical and mental health services while maintaining safe separation for both emergency care and SARS treatment areas.

While all parts of the system can improve, the emergency preparedness plans given the degree of interconnectedness within the overall healthcare system, at the Scarborough Hospital we believe we demonstrated an effective incident management response and showed that there is a way to create flexibility to allow a rapid response to an emergency like SARS.

We learned too that we didn't have to close a facility during an infectious disease outbreak. We acted prudently when we first encountered SARS, closing down emergency and ICU services at our Grace site, followed a few days later with the suspension of all other services.

Remember, SARS was a whole new experience for us and during those first few days with no background about SARS, we had to make some quick decisions. Closure was prudent.

In later weeks, with more information about the infection, with enhanced screening, extreme vigilance and strict isolation precautions in place, we demonstrated that we could safely treat SARS patients for this illness while, at the same time, providing care for others.

We also observed the need for centralized human resource management. Historically the Scarborough Hospital has not deployed outside agency nursing support and we have a very high mix of full-time staff.

However, during extraordinary circumstances, where there are extreme shortages, as staff became sick or quarantined or in times of increased demands, such as caring for isolation requirements for all patients, a centralized and automated staffing and scheduling system for human resource management becomes a more essential tool.

This tool makes our management system more responsive to immediate staffing needs in the hospital and also allows for faster tracking and information flow between operations departments, infection control and occupational health.

More broadly, and ideally, there should also be an external and centralized system for locating specialty expertise like additional health human resources. This would be particularly critical for smaller organizations to access help in a timely way or when we find ourselves in extraordinary circumstances and the expertise required is very specialized.

Finally, SARS brought us together in ways that we had never before experienced. The control and coordination of information, the development of care

protocols and the overall management of this public health crisis was the direct result of close collaboration among our senior leadership teams, medical chiefs of staff, clinicians, and academics.

As challenged as we were with so many unknowns about this new disease, our staff and researchers facilitated the formal study of this new illness. We contributed significantly in the scientific research that led to the following early knowledge about SARS.

The agent was identified as a corona virus. The most frequent symptoms that are reliable for establishing diagnostic criteria, the high risk factors associated with negative outcomes, the transmission patterns of the disease and the immediate psychological and occupational impact.

The results of such studies that we have participated in to analyse the most effective strategy for protecting healthcare workers from this disease will be available soon.

We are also in the process of establishing studies exploring the impact of different treatment approaches and the long-term outcome of this disease and identification of the indicators from blood studies and diagnostic imaging that could predict different outcomes.

I'm often asked what would happen if SARS hit the Scarborough Hospital again. I can tell the Commission

175

that SARS has been a very important learning experience for us. Because the Scarborough Hospital, which I have been associated with for seventeen (17) years has such a high patient volume and critical geographic location, we see and respond to a wide variety of clinical cases and healthcare issues.

As a result, we have built a reputation as an urban community hospital that consistently finds innovative ways of responding to an ever-changing service environment. Our response to this crisis was consistent with that reputation.

Every single day I come to work, our team of nurses, physicians, all hospital staff, infectious control specialists, support staff, administrators, and prove their courage confidence and leadership and they did so during SARS.

It is critical for all of us to remember that SARS came on us fast, was completely unknown in those early days, there was no warning, little time for training or pausing to reflect. Throughout this extraordinary crisis we implemented all of the provincial directives.

At both sites, we completed an exhaustive internal and external audit process which demonstrated excellent attention to required infection control practices and compliance with all provincial directives.

176

Our hospital is safer. I have been asked, did everything go the best way all the time? On balance, I can say the system worked, and our hospital worked well and it will work even better if there is a next time. Thank you.

MR. JUSTICE CAMPBELL: Thank you. The next presenter is the Ontario Hospital Association.

(BRIEF PAUSE)

MS. HILARY SHORT: Good afternoon, Justice Campbell. My name is Hilary Short. I am the interim president and CEO of the Ontario Hospital Association. The OHA is the collective voice of Ontario hospitals. It is a leader in shaping the future of the health care system.

We foster excellence, we build linkages with the community and advocate for quality healthcare. We have a seventy-nine (79) year history of innovation in the healthcare sector. We established the Ontario Blue Cross, the hospitals of Ontario pension plan, the Health Care Insurance Reciprocal of Canada.

We got together with the hospitals for central collective bargaining and most recently have supported hospital report card. We very much want to be part of the innovations that lead to the design of the new normal system.

Our core business is in support of hospital

governance and management are advocacy, province-wide human resources and collective bargaining and educational services. We are not, however, a regulatory body.

We want to speak first about the backdrop to SARS. SARS hit an already fragile hospital system. Hospitals have been cutting more -- have cut more than ten thousand (10,000) beds from the system during the past decade, and despite considerable funding announcements from the provincial governments, all types of hospitals in all regions of province face significant funding challenges.

In 2003/2004 fiscal year, we are already facing a five hundred million dollar ($500,000,000) shortfall. We face an outdated capital infrastructure, physical plant, information and communications technology.

We estimate from a survey of our members that over three (3) years, ideally, we need an additional eight billion dollars (8,000,000,000) to rebuild the capital infrastructure, and, even more importantly, critical human resource shortages have become a provincial and a national issue. Again, in terms of a backdrop, national studies show that Ontario hospitals are among the most efficient in the country.

Perhaps, though, efficiency has been taken too far. As many presenters have spoke to you, hospitals are at capacity -- high capacity. Occupancy rates are frequently

over 95 percent, in the GTA even higher, which we consider to be unsafe.

There is no surge capacity or redundancy to deal with major emergencies and with the changes we've seen considerably increased workload pressures on all our staff.

Furthermore, as SARS has shown us, our Public Health system is fragile; has been downloaded to the municipalities and is under-resourced.

SARS was an unprecedented event. It was a virulent communicable disease we have not seen before. We did not know its origin, at the beginning, as to how it was transmitted, incubation periods, the treatment and long term effects. The vague symptoms were easily confused with other illnesses, high fever, dry cough, shortness of breath or breathing difficulties; even malaise was mentioned.

It was a difficult disease to diagnose and we were all in the hospital system learning in real time and questions still remain. Given that, everyone involved maximized the tools that were available and the resources that were available.

In terms of its impact, the SARS outbreaks have changed the landscape of healthcare forever and despite the heroic efforts of all involved, we simply were not equipped to deal with the crisis on an immediate basis.

We need to fundamentally rethink our system

179

and how all components of that system fit together. It has shown us that at this point we have no flexibility to deal with disasters of this magnitude. It has had a huge financial and human resources impact.

We also saw across the province, not just in the GTA, reduction in elective surgery. We also in the GTA saw reductions in emergency and trauma services, as well as diagnostic services.

We still have a significant backlog of cases and it is unclear and maybe never will be quite clear what impact that had on our population in terms of the services that were not provided.

Speaking from the vantage point of the Ontario Hospital Association, I just wanted to talk about our role a little bit. It was to support our hospital leaders, our hospital administrators and senior managers and clinicians.

We provided a conduit for information sharing among hospitals, the Provincial Operations Centre, our unions, the Ministry of Health and Long Term Care, and the Ministry of Labour. We participated in and coordinated daily teleconferences with CEOs, clinicians and others.

We did some web posting and shared many bulletins of information and we tried to exchange information with all of our hospital community, particularly the communicators who were so key during this crisis.

180

The human resource issues were complex, challenging, and without precedent. We formed a SARS HR working group -- human resources working group, to provide advice to the Ministry of Health and Long Term Care and particularly on designing the SARS compassionate fund.

We were in continuous discussions with our unions, particularly the Ontario Nurses' Association. We provided guidelines to hospitals on issues such as compensation and we worked closely with the Ministry of Labour to try and address the health and safety issues.

We also set up a web-based SARS volunteer roster of healthcare professionals willing to help in the GTA. Subsequent to the outbreaks, we have received a research grant from Imperial Oil to help work on a project to improve personal protective equipment.

In terms of the OHA's perspective, we believe there was outstanding leadership, dedication, and commitment shown by all involved to address this crisis.

Government officials, hospital leaders, public health officials, physicians, nurses, all front line health care professionals, worked night and day under extremely difficult conditions to contain the outbreak but we did lack the knowledge we needed, the system capacity and flexibility, the resources and the necessary linkages between governments and other components of the system.

181

I wanted to speak briefly about three (3) major challenges faced by the hospitals: Communications, one I'm sure most of your presenters talked about; the system capacity and particularly, the human resource issues.

Initially, the relationship between the Provincial Operations Centre, the Ministry of Health and Long Term Care, Toronto Public Health and the Ministry of Public Safety and Security was unclear. The process of managing by directives was quite unprecedented and turned out to be cumbersome but it was the only tool we had at our disposal at the time.

There was no established mechanism for communicating with the hospital industry and healthcare organizations, especially after hours and weekends, particularly at the beginning and we had to work on that as we went through. We had to continue to develop protocols in real time.

In terms of the human resource challenges, the principal issue was a critical shortage of the human resources that were needed; particularly in the areas of infection control, intensive care, emergency, and respiratory therapy.

We were very worried early on by the shortages of protective equipment and the need to protect the supply chain. We also challenged by the fact that many employees

182

work for multiple employers.

As we went on the decision was made to try and reduce our healthcare professionals to work at two (2) sites which, again, reduced the numbers of staff that were available. We also had issues of how to use human resources in the screening process.

The compensation issues presented major challenges. We had many questions to deal with. How were staff to be paid if they are sent home or reassigned? Are staff on home quarantine to be treated as sick? What if they are part-time and not eligible for sick leave? If it is work-related should the WSIB compensate for the quarantine or hospitals and how could we possibly compensate management and other front line healthcare workers for working round-the-clock and there were many other human resource issues.

As you have heard from many presenters, staff on work quarantine had significant implications on their quality of life. They had many personal challenges and you will hear time and time again, as we have, those many stories of hardship by those working in the system.

We had significant challenges and the pressures on healthcare workers who were caring for their colleagues as SARS patients. We found in the first outbreak the phase was primarily fear and concern and as it went on longer, we got into issues of fear and mistrust, anger and

fatigue. All of them quite natural to understand given the unprecedented nature of the situation.

We believe it will have lasting impact on our human resources in Ontario and much work is needed to heal our staff and our workplaces. Occupational health and safety and infection control need heavy investment of time and money and there are issues too of how to rebuild trust in management during this difficult time.

In terms of the capacity challenges, many times we heard during the crisis that a situation was critical, it was grim and particular, we were worried by the shortage of intensive care unit beds across the Province. The closure of emergency rooms created even greater pressure.

We learned that our physical facilities are not configured for best practices in infection control and heightened vigilance. We had a lack of single occupancy and negative pressure and isolation rooms. The restriction on visitors -- or the banning of visitors in some cases provided great inconvenience for patients and their loved ones.

The financial impact of SARS was significant due to the loss of revenue and the cost of heightened vigilance. So how can we benefit from our experience and what are the lessons learned as we go forward.

We owe it to the community and to all our healthcare professionals to plan for what might be on the

horizon with the next disease or another outbreak of SARS. As you have heard, many emergency response processes already in place. There has been significant learning and hospitals have been quick to respond and make changes.

More improvements will be made as we build on lessons learned. While individual hospitals have demonstrated and continue to demonstrate great resilience and strength during the crisis, we need to develop a much stronger system level emergency plan.

Again, how can we improve our response to future outbreaks? First of all, our objectives have to be the ongoing enhancement of emergency preparedness and coordination among all levels of government, hospitals and all healthcare providers including public health.

We need an improved ability to treat future deadly diseases and to protect our citizens and our healthcare professionals from future outbreaks. We need to enhance our workplace safety and wellness programs. How can we achieve these objectives?

We must provide leadership and support to the hospital system and emergency preparedness. We want to do all we can to provide the input to you, Justice Campbell, and to all of the other commissions and expert panels that will be looking at this whole crisis.

In the meantime, we need to strengthen our

partnerships with Government, with Public Health, with other agencies and stakeholders dealing with emergency preparedness.

There are a number of areas in which we need to -- a number of issues that need to be addressed and they come into these categories, human resources, capacity and system issues, our information systems, infection control, communications an research.

In human resources, we will need to look further at the best practice relating to staff mix ratios of full time to part time. We will need to review and address issues relating to staff working at multiple sites.

We need to address health and safety programs in hospitals, particularly personal protective equipment. We need to evaluate and manage what the roles are of our volunteers and students within and between facilities during an emergency and outbreak of this kind.

We need to address the statutory powers during a provincial emergency, including whether there is any need to override employment laws, collective agreements and so on. We need to -- an increased focus on education and training on infection control for healthcare professionals.

Hospitals must have the human and the financial resources needed to manage outbreaks. Our occupancy rates are too high and we have no flexibility to

deal with these emergencies. Therefore, we need to find a way to build in surge capacity so that we can preserve our human and physical resources, our beds and equipment in times of emergency so that we can allow for the continuance of services such as trauma, cancer care, cardiac care, all of the birthing, obstetrical work, because we know that particularly critical care and emergency services were threatened by SARS. We need to find ways for faster discharge of alternate level of care patients to the appropriate level of care, so that we use our resource effectively.

We do need a provincial authority to coordinate and manage system response in a health emergency. One of our hospitals has referred to this as the managing voice.

We need to look at a new code for large-scale infectious disease outbreaks. As you know, in this outbreak, we used code orange because that was the closest that we had, but that was really designed for a different kind of emergency where it was a plane crash or something of that nature and not to an outbreak of infectious disease.

We need organized formal and ongoing collaboration amongst government and different parts of the system given the interdependence among hospitals, public health, community laboratories and other community agencies

187

and we need to clearly distinguish responsibilities and accountability among different jurisdictions, federal, provincial, regional and municipal.

In terms of our physical facilities, we need to incorporate into renovation and construction projects best practices to address infection control and emergency management needs for ex -- for example, neg -- the building of more negative pressure rooms.

We need to coordinate supply and distribution of approved protective equipment. We also need to look at all our information systems. Our systems -- we need information systems that can accommodate centralized knowledge sources that would contain information of a clinical nature, epidemiological and other.

We need realtime data collection and analysis capabilities to support time sensitive decision making. We need system management information to identify available resources and maximize quick access to them.

When it's feasible, we need to have unique patient and provider identifiers and registries that need to be established to locate and track individuals.

In an ideal world, we really need electronic health records and shared databases to support the sharing of information between providers, jurisdictions and government agencies and enable active surveillance and tracking.

188

We need better communication tools which include e-mail, fax and phone and -- all connected together to connect relevant parties and facilitate sharing of information.

In the area of infection control, we need to establish centers of excellence and infectious diseases control. We need to develop and disseminate best practices in infectious diseases.

We need to consult with stakeholders and providers in the development of infectious disease control protocols. We need a better surveillance system, including early warning protocols and we need to enhance infection control practices throughout the healthcare system, reinforce by ongoing training and development of human resources.

On the communications front, we need to provide coordinated, accurate, trusted and timely information to the public and healthcare providers. As we went through this outbreak, these became developed but it took a while before they were securely up.

We need secure web sites, bulletins, daily updates and we need to provide support to clinical experts and maintain centrally a current communications database for relevant stakeholders and providers.

We need to establish a central coordinating body for communications between providers, essential

stakeholders and government bodies such as the Ministry of Health, the provincial and SARS operations centres and public health.

Providers need to be able to communicate directly with the Ministry to share critical information such as status changes and to receive clarification on directives on a round-the-clock basis during emergencies.

We need to clearly identify spokespersons during the crisis to avoid confusing and conflicting messages.

We need to communicate with the public frequently using as many media as possible, involving experts to provide reassurance and direction such as changes in a new normal environment, hand hygiene, visiting, travel, et cetera.

And here we want to complement the Ministry of Health and Long-Term Care on its daily communications with the public through Dr. Young and Dr. D'Cunha through the news -- and others, through news conferences and advertising.

On the research front, we must develop centres of excellence for disease control. We need to coordinate and support networks and activities, particularly in real time, during an outbreak to assist with quick solutions.

We need to invest in research to redesign the system so that we can cope with unknown disease entities

using evidence-based practice.

In conclusion, we need to prepare for future unknown disease entities. We need additional resources, human resources, infection control, capital and infrastructure to ensure system flexibility and surge capacity to address unforeseen emergencies. But we also need to recognize the heroic efforts and accomplishments of the healthcare sector while learning from our experiences.

Together we need to adopt a new philosophy towards health that focuses on patient and public safety, ongoing vigilance and prudence to protect ourselves.

From the hospital perspective, we need to view hospitals differently. We must understand that their focus is on caring and healing and we need to look at and address visiting policies that will be compatible with the new normal.

Our hospital leaders truly rose to the challenge. As you have heard, hospital leaders establish hospital-based emergency operations internally to manage the crisis round-the-clock.

They activated their Code Orange procedures. They heightened their vigilance in infection control surveillance. They quickly implemented communication strategies to keep their staff, patients, and communities informed of key developments.

They rebuilt and reconfigured their hospitals to create the facilities needed, including the negative pressure rooms. They built SARS screening and assessment clinics. They provided staff education and protective equipment.

Hospitals appreciate the financial compensation provided to hospitals and healthcare professionals by the provincial government. The Premier and the Minister of Health acted promptly on both fronts. We believe it is critical for the federal government, too, to step up to the plate and provide its fair share of compensation to Ontario.

Despite the stresses on the healthcare system, hospitals did contain SARS despite the tragedies, the hardships and the heroism. Success was due to the heroic efforts of healthcare leaders and staff who put aside their own fears to care for others.

In the battle against SARS healthcare professionals made huge sacrifices and with great pride our hospital leaders have told us about the courage, commitment, and professionalism of staff throughout isolation and Code Orange procedures.

Our association will continue to pay tribute to the thousands of healthcare professionals who were on the front line in the war against SARS, especially those who lost

their lives. We remember Nelia Laroza, Tecla Lin and Dr. Nestor Yanga. They dealt with something that we have never faced before and they did it twenty-four (24) hours a day, seven (7) days a week for numerous months.

It was exhausting for them, their families worried about them and they worried about the safety of us all and we thank you, for your are our heroes. Thank you for the opportunity to present to you.

MR. JUSTICE CAMPBELL: Thank you for your presentation.

The next presenters are the Ontario Association of Radiologists.

(BRIEF PAUSE)

DR. MARK PRIDITIS: Good afternoon, Justice Campbell. My name is Mark Priditis. I am a physician and I service the Chief Radiologist for the Rouge Valley Health System. I'm also the Executive Vice President of the Ontario Association of Radiologists and I am the chair of the OMA section on diagnostic imaging.

My presentation today is as a radiologist and as a member of the OAR. I am also in active practice at the Rouge Valley Health System and the Scarborough Grace Hospital and several independent health facilities.

During the SARS crisis, I was personally placed on quarantine and several of my medical, technologist and nursing -- nursing colleagues developed SARS.

I would like to thank you, Mr. Justice, for the opportunity to present today. I believe this is a very important part of the process of ensuring Ontario is better prepared to deal with another public health crisis of this nature in the future.

I'm hopeful that the results of your Commission will help all of us prepare, cope and deal with any future public health crisis in a more comprehensive, cooperative and cohesive manner.

The majority of my presentation today will deal with the implications of SARS on independent health facilities. I will also make a few short observations on the impact on hospital radiology departments, based on my personal experiences with this crisis, and will finish with some specific recommendations.

What is the Ontario Association of Radiologists? We are a voluntary professional body. We represent seven hundred (700) Ontario radiologists.

Radiologists practice medicine in both hospitals and more than six hundred (600) diagnostic imaging independent health facilities or IHS. They're also commonly called community imaging clinics. In Ontario, most

radiologists practice in both the hospital and IHS practice settings.

What is radiology? In laymen's terms, radiology is a medical speciality that uses sophisticated imaging equipment to view the inside of a human body.

Radiologists are the physicians who specialize in creating and interpreting diagnostic images in order to detect and diagnose disease. We also perform minimally invasive procedures or surgery using imaging for guidance.

Some of the common imaging equipment used in radiology include x-ray, ultrasound and mammography. Higher tech imaging we use includes CT, Magnetic Resonance Imaging and Angiography and Positron Emission Tomography.

Radiology is used in the diagnosis of virtually ever major medical condition and the leading causes of death including cancer, heart disease and stroke. Radiology plays a key role in the diagnosis of all patients who are exhibiting respiratory symptoms.

In most cases, patients with respiratory symptoms for many illnesses, including SARS, receive chest x-rays as a routine and key part of the diagnostic work up. After a diagnosis is made, many more chest imaging studies may be performed to monitor the disease.

Throughout the SARS outbreak, radiologists and our technologist colleagues played a key role in the

provision of imaging services used to identify SARS patients.

What was the role of diagnostic imaging in SARS? Well, specifically during the outbreak, patients exhibiting SARS symptoms were sent for x-rays and CT scans to help diagnose and monitor the disease. CT scans were used in the identification of SARS, in some cases, as they were shown to be the most sensitive test to demonstrate the first pulmonary findings early on in the Hong Kong SARS experience.

CT is also very useful in monitoring the long term damage to the lungs that may be caused by SARS.

Community imaging clinics and hospitals are the only providers of radiology services in Ontario, so anyone who needed a chest x-ray had to go to either a clinic or a hospital radiology department.

What was the role of independent health facilities in Ontario? As I said earlier, there are about six hundred (600) radiology clinics in Ontario communities. About 50 percent of all radiology services are delivered in hospitals and the other half, or 50 percent, in community imaging centres. That includes, perhaps, the majority of chest x-rays. In many cases in Ontario during the SARS outbreak and on an everyday regular basis, patients choose to have that radiology examination performed at a community imaging clinic.

All Ontario patients exhibiting SARS symptoms were referred for radiology services. As you heard yesterday from Dr. D'Cunha, most SARS patients had X-ray findings. Also, the sickest and the most infectious patients tended to have the most severe chest X-ray findings and often they were the ones that received imaging services most frequently. Most patients who were eventually diagnosed with SARS had multiple chest X-rays.

Many of these were referred for these diagnostic examinations by their family physician and in the case of those requiring X-rays, several that we know of went directly to community imaging clinics.

In fact, one of the first SARS cases from the original family was imaged at a clinic. There were several others throughout both SARS and one in SARS II that went through these independent health facilities.

Some patients, in fact, we know of at least a few healthcare workers decided to seek services at clinics due to fear associated with visiting hospitals during the SARS crisis.

At the same time as patients with SARS-like symptoms were getting radiology services, thousands of other patients were visiting these same clinics for diagnostic tests ordered by their family physicians and other specialists for a host of clinical indications.

Due to the provincial government directives, hospitals in Ontario restricted patient access and for varying amounts of time they cancelled all out-patient radiology services at many hospitals. This meant that during the critical period of the SARS crisis community imaging clinics were, in some cases, the only providers of radiology services in areas of this province, particularly during the height of the SARS outbreak.

For example, for a short period of time in East Toronto the Rouge Valley Centenary, Scarborough Hospital General and Grace Divisions and the North York General were all closed to out-patient services at the same time. These hospitals serve at least five hundred thousand (500,000) people. The only providers of imaging at that time were the independent health facilities in the area.

Now, I'd like to talk about the provincial communications and this is a very important point because, despite the important role played by IHFs during this public health crisis, the Ministry of Health overlooked community imaging clinics in its communications and information network.

Also, the Ministry of Health apparently did not develop or disseminate any specific guidelines that recognized the unique nature of these facilities. It became clear to us early in the crisis that there was a concerning

breakdown in the Ministry of Health policies, safety measures, communications procedures, and response efforts.

The Ministry of Health's lack of consistency in the application of its SARS response had the effect of creating a double-standard for the protection of patients, medical staff and physicians working in diagnostic image practice settings.

The Ministry of Health's breakdown overlooked the needs of IHFs from a communication standpoint and in terms of the provision of protective equipment in particular.

While the Ministry of Health was ensuring hospitals were receiving daily updates, access to safety equipment and information specifically directed at -- while the Ministry of Health was ensuring hospitals were receiving daily updates and access to safety equipment specifically directed to areas of practice, it was virtually the opposite for clinics.

Not only was personal safety equipment, specifically gloves, goggles, masks, gowns, never made officially available by the Ministry of Health for independent health facility staff, the Ministry of Health did not help coordinate a plan to enable independent health facilities to obtain proper equipment.

For a number of reasons, it was nearly impossible to purchase û95 masks in Ontario during the early

stages of the SARS outbreak, which was especially concerning. The failure to recognize the needs and to work with frontline independent health facilities continued throughout the outbreak.

As I am sure you can understand this resulted in a truly frustrating and very worrying situation for those of us -- the OAR contacted Ministry of Health officials on numerous occasions by phone and through numerous pieces of direct correspondence. We requested a plan to supply and find safety equipment and provide proper information to clinics.

Despite the numerous requests, the Ministry of Health did not provide specific clinic information until very late in SARS II. What seemed clear to radiologists and those with knowledge of radiology and its importance in this outbreak was that the Ministry of Health seemed to have limited knowledge of how diagnostic imaging services are delivered and how this aspect of the health system would be impacted during a crisis.

It is our view that this information gap put radiologists, technologists, medical staff, and patients at greater risk than was acceptable in this situation.

The lack of information being disseminated to clinics was further complicated by the apparent decision of the Ministry of Health to offload the important

communications pertaining to independent health facilities to a non-medical organization known as the IDCA.

It is our understanding that the majority of independent health facilities in Ontario are not members of this organization. Many of our members did not receive any information from this organization. It's our view that this was an inappropriate response by the Ministry of Health which remains very difficult for us to understand.

Radiologists are very concerned in principle about the concept of offloading an issue of such importance to any association other than a medical association.

In fact, there are only a few directives given by this organization which were consisting of several paragraphs and some general Ministry of Health information. We informally surveyed several independent health facilities in key areas affected by SARS and only a minimal number of those IHF's stated that they had received any of this information. In our view, IHF's needed much more detailed, specific and timely information in a process to ensure that it reached all those that needed it.

Well, what was the role of the OAR and what did we do given this situation? From the earliest days of SARS -- of the SARS crisis, radiologists, including OAR board members, were affected in both the hospitals and the independent health facilities. This alerted the OAR and

despite the Ministry of Health not responding to our concerns, the OAR immediately worked to assemble information based on the international experience.

We worked to develop and adapt guidelines and aggressively communicate any clinic and safety information that we could to the independent health facilities. We had -- we -- we established a comprehensive fax, an e-mail broadcast network. The OAR sent out numerous information sheets and information that was direct -- directed at the practice of radiology, specifically in the community clinics.

Broadcast began in March, and continued throughout the update with updates as new developments and changes in policy occurred. In addition, the OAR acted as a conduit for directly disseminating and circulating public health updates in a manner that encouraged safety precautions that were applicable in IHF settings.

The OAR set up a comprehensive web portal which included dozens of information sources, information and safety documents, as well as clinical information directed specifically at radiologists. In addition, the OAR served as a clearing house for information and a conduit to help radiologists in both hospital and clinic practice communicate with others to ensure the best and most current clinical data was being communicated throughout the radiology community in

Ontario.

I'd like to talk about the role of another organization called MICO or Medical Imaging Clinics of Ontario. This is a company that was formed by a radiologist to supply IHF's with film and other types of products. It's -- it is the largest supplier to IHFs in Ontario.

Working closely with the OAR and medical equipment suppliers to secure and distribute û95 masks, gowns and other protective gear, we were successful in reaching a large number of the IHFs, including a large number of family physician offices who couldn't get access to that equipment.

In fact, MICO was instrumental in securing American sources of û95 masks when they were really completely unavailable through conventional means in Ontario. They were an important player in ensuring Ontario imaging clinics were properly prepared for this public health crisis.

This made Nû95 masks and other necessary supplies available in member IHF's before they were available in other physician's offices. We believe that these activities were important to public safety during the outbreak and resulted in a safer environment in OAR member-owned clinics.

As imaging specialists, we did the best we could to assemble, adapt and disseminate important information but we're imaging specialists; we're not

infectious disease specialists or public health specialists and there's no doubt in our minds that had the MOH responded to our concerns and worked with imaging specialists to develop a detailed plan, we could have done much better.

Unfortunately, it is clear that many other IHF's that are not member-owned IHF's in this province were, in effect, operating in a vacuum during the SARS crisis.

It is our hope that, in the future, a process will be in place to ensure a coordinated, medically-led response to any similar healthcare crisis that we face. This process should engage the proper medical and other healthcare leaders and their organizations and be as de-politicized as possible.

This process must also give the experts the authority and means to communicate and also to disseminate necessary equipment rapidly.

I'd now like to talk a little bit about my personal hospital experience and make a couple of observations which -- which may not have been made by others and really apply specifically to radiology.

As a radiologist at the Rouge Valley Health System and the Scarborough Grace, I was involved in the care of a large portion of Canadian SARS patients.

In my capacity as Chief and Medical Director of Diagnostic Imaging at the Rouge Valley Health System, I

was responsible for supervising technologists and other staff in working with infection control and implementing safety policies in our department.

Many medical staff, physicians specifically, work at both the Scarborough Grace and the Rouge Valley Health System. This resulted in important information passing very quickly from the Grace to the Rouge Valley Health System in the early days of SARS.

Another interesting feature was that many of the physicians, particularly members of my group and other physicians, have friends and family in the Far East; physician colleagues, including medical leaders in the Far East and they were in frequent communication with these physicians early on.

It was our impression that information available in the Far East was -- was more rapid, more detailed and less filtered than that -- was -- that was available here.

As a result of this, and several determined and perseverant physicians and other professionals, strict infection control measures were introduced at the Rouge Valley Health System early on in the SARS crisis.

In fact, in some areas of the hospital, these were implemented well before Ministry of Health directives and in some department that were sometimes overlooked such as

205

the radiology departments.
I believe this was instrumental in there being no known transmission of SARS to a patient or staff member at the Rouge Valley Health System despite looking after about 20 percent of the total number of SARS patients in Canada.
I must give particular credit to Dr. Ian Kitai, at Rouge Valley Health System for his unwavering dedication and determination during the SARS outbreak.
I'd like to comment also on the need to re-engineer hospitals and this was mentioned also by the Ontario Hospital Association. Most SARS patients received many chest X-rays during their stay in the hospital. Many of the sickest patients had chest X-rays daily and many patients required CTÆs.
For those of us dealing with many SARS patients in hospital, the impact on the radiology department was profound. For example, many of our -- of our technologists spent the greater part of each and every day getting in and out of protective gear and X-raying SARS patients.
If a SARS patient required a CT or an ultrasound or an interventional procedure that had to be done in a department, the room that that patient was transferred to would have to be effectively shut down to other sick patients for a large proportion of the day and this was

206

occurring in a system that was already facing extreme waiting lists and overcrowded waiting rooms.
For example, if a multi-site hospital only had an MRI or a CT at one of the -- at one of its sites and that site was closed, then urgent patients from the other site with diseases like strokes, cancer or those with traumatic injuries were effectively excluded from getting the imaging that they needed to optimize their care.
I'd like to go through some recommendations, now, to finish my presentation. Number 1: The Ministry of Health must develop a formal process that allows for the automatic ongoing communications with all regulated health facilities whether they be public hospitals, independent health facilities or nursing homes, et cetera.
Number 2: Public health issues, by definition, have serious medical implications which demand that there be a formal system by which all appropriate medical leaders and practitioners are directly involved in providing advice, both to the public health care officials as well as providers in that specific healthcare area.
Three: There's a need for flexibility in the occurrence of a public health issue that ensures that medical experts and their professional organizations are engaged by government to co-develop appropriate response plans and to advise on pertinent matters that will protect the public

interest.

Four: In a time of an urgent public crisis, the government should not rely solely on umbrella organizations, for example, the Ontario Medical Association, as the sole source of advice and assistance on complex and specialized medical issues, recognizing the organizations, such as this, are more suited to provide assistance at a more generalized level.

Medical specialty sections of the OMA should be engaged directly to provide assistance in conjunction with other affiliated professional medical organizations in specific areas.

Five: The Ministry of Health has a duty to provide appropriate safety equipment to all publicly-funded healthcare facilities on an equitable and timely basis.

Six: Equipment must be provided and distributed to all publicly-funded healthcare facilities in an expeditious and equitable manner in order to contain the -- an outbreak and provide critical public safety measures. When supplies are limited, discretion should be applied to respond to those areas most impacted or likely to be impacted.

Seven: If the Ministry of Health is unable to provide direct communications with physician IHFs they should engage the OAR as the provider of communication materials to

IHF radiologists.

Eight: In the case of a public health crisis, it should be established government policy not to use or designate an industry organization because they are unable to provide medical advice or diagnostic imaging expertise.

Nine: Ministry of Health must create an action plan, in cooperation with radiologists who work in both hospital and IHF settings, to ensure a comprehensive approach to another outbreak.

And ten: An education awareness program should be undertaken to ensure that the Ministry of Health, public health and other health organizations have a clear understanding of the role of independent health facilities in providing diagnostic imaging services to patients, especially in light of the prominent role played by IHFs in the SARS crisis.

And, finally, number 11: SARS clearly outlined the urgent need to increase the capacity of imaging departments in hospitals and re-engineer these departments and other areas of the hospital so that patient flow is understood.

There needs to be some excess imaging capacity built into key areas so that the needs of those with infectious diseases, as well as the many, many other important conditions can also be cared for regardless of the

crisis that we face.

Once again, we'd like to thank you for the opportunity, Justice Campbell, for the opportunity to speak at this presentation. We have faith that you will reflect on everything you've been told and it will help provide us with advice to rebuild the healthcare system and do a better job in the future. Thank you.

MR. JUSTICE CAMPBELL: Thank you for your presentation. We'll adjourn until ten o'clock tomorrow morning.

--- Upon recessing at 4:49 p.m.

Certified Correct

_____

Wendy Warnock
Court Reporter